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HEALTH CARE REFORM

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Health Care Reform, Serial No. 103-...

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

VOLUME XI

President's Health Care Reform Proposals: Impact on Providers and Consumers

OCTOBER 7, 21, 22, 26; NOVEMBER 15, 1993; FEBRUARY 1 AND 4, 1994

PART 2 OF 3

OCTOBER 26, AND NOVEMBER 15, 1993

Serial 103-90

Printed for the use of the Committee on Ways and Means



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HEALTH CARE REFORM

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PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON PROVIDERS AND CONSUMERS

TUESDAY, OCTOBER 26, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.**

The subcommittee met, pursuant to call, at 9:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

BACKGROUND:

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

- (1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;
- (2) Role and functions of the proposed health alliances;
- (3) Health cost containment, including premium caps and alternative mechanisms;
- (4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

- (5) Impact of the plan on underserved inner-city and rural areas;
- (6) Impact of the plan on low-income populations generally;
- (7) Medicare savings proposals;
- (8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;
- (9) Alternatives to the plan, including single-payer options, and other managed-competition options;
- (10) Administrative simplification under the plan;
- (11) Quality assurance;
- (12) Fraud and abuse measures;
- (13) Retiree health benefits;
- (14) Long-term care benefit;
- (15) Proposed standard health benefit package;
- (16) Graduate medical education and academic medical centers;
- (17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 6, 1993

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will continue its series of hearings on issues relating to the President's health care reform proposals with two hearings focusing on testimony from Administration witnesses.

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m., will begin at 10:30 a.m. All other details for this hearing remain the same. (See Subcommittee press release #18, dated September 30, 1993.)

The Subcommittee will continue its hearings on Friday, October 15, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The dates, times, and rooms for subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President has put forward a comprehensive and complex plan to address the critical goals of universal coverage and cost containment. As a follow-up to full Committee hearings with the First Lady and Secretary Shalala, the Subcommittee will hold two hearings with additional Administration officials to explore the proposed health plan in detail."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

BACKGROUND:

On October 12, the Subcommittee will receive testimony from the Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck. Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

Judy Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee on Friday, October 15th. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

* * * CHANGE IN SCHEDULE * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 8, 1993

PRESS RELEASE #19-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES SCHEDULING CHANGES FOR HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today scheduling changes for the hearings on issues relating to the President's health care reform proposals with testimony from Administration witnesses. (See Subcommittee press release #19, dated October 6, 1993.)

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., will be held on Thursday, October 14, beginning at 10:00 a.m.

On Thursday, October 14, Judy Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

The Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck, originally scheduled to appear on Tuesday, October 12, 1993, instead will appear before the Subcommittee on Friday, October 15, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

For additional information about these hearings and other Subcommittee hearings, see Subcommittee press releases #18, dated September 30, 1993, and #19, dated October 6, 1993.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 15, 1993

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The Subcommittee will hold a hearing on Thursday, October 21, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., with testimony from representatives of consumer groups.

On Friday, October 22, 1993, the Subcommittee will hear testimony from provider groups beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about the hearings, see Subcommittee press release #18, dated September 30, 1993.

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FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 20, 1993

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
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ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The dates, times, rooms, and topics for the additional hearings are as follows:

Tuesday, October 26	9:00 a.m.	1100 Longworth	Provider groups
Thursday, October 28	10:00 a.m.	1100 Longworth	Labor representatives
Tuesday, November 2	10:00 a.m.	1100 Longworth	Long-term care issues
Thursday, November 4	11:00 a.m.	1100 Longworth	Impact on the economy and jobs
Friday, November 5	10:00 a.m.	1100 Longworth	Role of State governments and health alliances
Tuesday, November 9	10:00 a.m.	1310A Longworth	Issues relating to risk selection and adjustment by health plans
Monday, November 15	10:00 a.m.	1310A Longworth	Health care cost containment

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

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* * * CHANGE IN ROOM AND TOPIC * * *

FOR IMMEDIATE RELEASE
MONDAY, NOVEMBER 8, 1993

PRESS RELEASE #21-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN ROOM AND TOPIC FOR THE HEARING ON
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals scheduled for Monday, November 15, 1993, at 10:00 a.m. in room 1310A Longworth House Office Building, will be held instead in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. (See press release #21, dated Wednesday, October 20, 1993.)

The topic of this hearing will not be health care cost containment. Testimony will be heard instead from public witnesses on issues relating to benefits under the President's health care reform proposals.

The Subcommittee hearing on health care cost containment will be rescheduled at a later date.

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FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 14, 1994

PRESS RELEASE #23
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional days of hearings to receive testimony from the public, as part of its series of hearings on issues relating to the President's health care reform proposals.

The first hearing will be held on February 1, 1994, in room 1310A Longworth House Office Building. This hearing will begin at 2:30 p.m. or, if necessary, upon completion of the earlier full Committee hearing.

The second hearing will be held on Friday, February 4, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will be individuals and organizations who have previously requested an opportunity to testify before the Subcommittee, in accordance with Subcommittee press release #18. All witnesses who will appear at these hearings will be notified in advance by the staff.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearings should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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* * * NOTICE -- CHANGE IN TIME * * *

FOR IMMEDIATE RELEASE
MONDAY, JANUARY 24, 1994

PRESS RELEASE #23-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A TIME CHANGE FOR HEARING
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals previously scheduled for Tuesday, February 1, 1994, at 2:30 p.m. in room 1310A Longworth House Office Building, will begin instead at 10:00 a.m.

All other details for the hearing remain the same. (See Subcommittee press release #23, dated January 14, 1994.)

* * * * *

Chairman STARK. Good morning. With the kind permission of the minority, some of whom will be with us, they have allowed us to begin the hearing. Today, the subcommittee continues hearings that were begun on Friday with testimony from groups representing health care providers.

As we have already learned, there are many diverse views of the President's plan. I hope that these hearings will address and help to resolve many of these complex issues. As I have previously indicated, I hope the witnesses will also comment on the various alternatives to the President's health care reform plan.

Due to the number of witnesses testifying, I intend to keep the hearing moving as quickly as we can in order to allow members to explore those issues about which they have questions or concerns.

In the absence of any opening remarks, I will call on our first panel, comprised of Alan Nelson, the American Society of Internal Medicine. He is the executive vice president. William Carey is the president of American College of Gastroenterology. David Tinkelman is the treasurer of the Joint Council of Allergy and Immunology. John Burton, board member and clinical director of the division of geriatric medicine, Johns Hopkins, representing the American Geriatrics Society. Robert J. Lloyd, chairman of the legislative affairs committee, the Council on Rheumatological Care, representing the American College of Rheumatology, and Eugene T. Davidson, who is president of the American Association of Clinical Endocrinologists.

Gentlemen, please proceed to summarize your testimony or expand on your written testimony. Without objection, all written testimony presented at the hearing today will appear in the record in its entirety. And I am going to ask each witness, particularly those who are now or have been recently in private practice, to answer one question sometime in the course of their testimony. For other perspective witnesses, I hope they will hear this as well.

We will have a lot of discussion about not only what benefits should be included in a package but the question of cost containment, which ranks high as a problem in getting this bill through. What I want to know and it is not necessarily an endorsement, but of all of the methods under which these private practices would operate, which is the least objectionable?

I don't suppose any of them will win your overwhelming endorsement. By that, I mean not necessarily in terms of the dollars you receive but in terms of hassle factor and convenience. If you had to pick a reimbursement, Blue Cross, Aetna, some preferred provider that you deal with, Medicaid or Medicare, if you had to pick one of those systems or if you wanted to rank a couple, we would be curious to know which of the systems you currently operate with is, as I say, least objectionable. I think that is probably the best rating that anyone could hope to get. And I would like to continue to ask the witnesses that during the course of the day's testimony.

Dr. Nelson, do you want to lead off?

STATEMENT OF ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. NELSON. Yes, sir, thank you.

ASIM believes the consensus for health care reform is fragile. It is already being threatened by an excessive dose of negativism. Too much of the emphasis has been placed on what is wrong with the President's plan, rather than on the many good ideas that are presented in the plan offered by the President and in the several other proposals that are being considered. Too many groups have objected to specific proposals without being able or willing to say how they would do things differently, and too often the entire proposal has been labeled as being unacceptable, when, in fact, the areas of disagreement are on a relatively few, albeit important, issues.

Instead of approaching reform in a negative spirit, ASIMs house of delegates, which is its democratically selected policymaking body, at its meeting just a little over a week ago adopted policies supporting a balanced and constructive approach to health system reform. Our statement identifies eight key elements of the President's plan with which ASIM is in general agreement, and we are particularly pleased that the Clinton proposal has more concrete initiatives to help rebuild primary care than any other proposal that has been offered so far.

The President's proposals to guarantee free choice of physician, to implement antitrust and medical liability reforms are steps in the right direction. Our testimony includes additional recommendations for improvement in these areas.

Physicians have a great deal of concern about the proposed cap on overall health care expenditures and the related issue of how much authority the National Board and the health alliances should have to set rates and regulate premiums in an effort to not have the issue of global budgets be one that polarizes the entire debate over health reform.

ASIM has developed its own ideas of what could serve as an acceptable alternative, consists of three elements. First, spending targets would be negotiated instead of a fixed, formula-driven cap on overall spending.

Second, premium increases would be restrained by limiting at a median level the amount of an employer's contribution to the premium that is tax deductible instead of giving the health alliances the authority to limit premium increases.

And, third, fees in the fee-for-service market would be restrained by competition and consumer knowledge of price and value.

ASIMs proposal has two principal advantages over caps. It gives all of the stakeholders a voice in establishing the spending target and in deciding what should be done if the targets are exceeded. It also relies more on market forces to keep premiums and physician fees to a reasonable level instead of price controls. Finally, ASIM is concerned that the proposed cuts in Medicare cannot be achieved without compromising patient care.

In conclusion, let me emphasize ASIMs strong commitment to work for enactment of comprehensive health system reform legislation. ASIM believes that it is time to put an end to "just say no" politics, begin the task of working together to identify the key elements that command substantial support and to iron out differences on the others.

Thank you.

[The prepared statement follows:]

American Society of Internal Medicine

Testimony to the Ways and Means Committee

October 26, 1993

Introduction

I am Alan R. Nelson, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). ASIM is a national medical specialty society representing physicians who specialize in internal medicine and its subspecialties. Our policies are established by our House of Delegates, which consists of democratically-elected internists from state and subspecialty societies.

Just a little over a week ago, ASIM's House of Delegates concluded four days of discussions and policy debates on health system reform. It heard from several members of Congress who presented their views on reform, including two members of this subcommittee, Rep. Jim McDermott and Rep. Nancy Johnson. It also considered a wide range of recommendations for policies on the President's health system reform proposal and other proposals in Congress. Having heard their debate and discussions, I am now able to report to you how physicians who specialize in internal medicine—the nation's largest specialty—view health system reform.

Building a consensus for reform

ASIM believes that the consensus for health system reform is a fragile one. Most Americans seem to want change, but they also fear what they will be asked to give up to achieve it. Physicians are no different. The consensus for reform will shatter if all that people hear is what they will lose from health system reform, rather than what we all stand to gain.

We believe that this consensus is already being threatened by an excessive dose of negativism. The debate on the means to achieve universal coverage has already become more polarized than it should be. Too much of the emphasis has been on what is wrong with the President's plan, rather than on the many good ideas that are presented in the plan offered by the President—as well as in the several other proposals that are being considered. Too many of the statements have taken on a tone of solid opposition to one proposal or another, rather than one of being open to discussion on ways to reconcile areas of disagreement. Too often groups have objected to specific proposals without being able or willing to say how they would do things differently. Too often the entire proposal has been labeled as being unacceptable, when in fact the areas of disagreement are on a relatively few, albeit important, issues. Too much is said about how one proposal is better than another, without acknowledging that there are positive elements in virtually all of the proposals.

The way to counteract the negativism that threatens to shatter the consensus for reform, we believe, is for each of us to take a constructive "let's get it done" approach. ASIM for its part will continue to emphasize what is good in the President's proposal—as well as in the proposals of others. We intend to keep our sights on the greater end—getting legislation enacted next year that achieves universal access to an affordable standard benefits package—while debating the means to get there. When we disagree with the proposals offered by the President or others, we will seek to offer constructive alternatives that could form a basis for reconciling our differences, rather than just standing in opposition.

ASIM also believes, however, that achieving consensus also requires a willingness to consider the legitimate reservations individuals and groups have about the President's proposal, as well as the proposals of others, and to consider their alternative recommendations. We have been encouraged that the White House has expressed a willingness to consider accepting constructive alternatives as part of the legislative process. If physicians feel that their concerns not only are being listened to, but that a good faith effort will be made to consider changes that will address those concerns, then we believe that the medical profession will continue to stand in support of comprehensive reform. If they believe that their views are disregarded or dismissed, or if they are viewed as being obstructionist if they offer alternative suggestions, then it will naturally be more difficult to win their support.

I am very pleased that ASIM's House of Delegates adopted policies supporting a balanced and constructive approach to health system reform, one that I believe stands the best chance of strengthening the consensus for reform. The internists represented by our House of Delegates reaffirmed their commitment not only to the goal of comprehensive reform of the health care system, but to achieving that goal as expeditiously as possible. Internists believe that incremental reforms that fall short of guaranteeing that all Americans have access to an affordable standard benefits package would not be acceptable.

The internist-delegates also commended President Clinton for coming forth with a constructive and courageous health system reform proposal that provides a framework for achieving this goal. As outgoing ASIM President Richard Ruppert, MD, said in an address to the House of Delegates, "The comprehensive health care proposal of President Clinton is a remarkable achievement for the government, both in the undertaking of the process and also in addressing the wide variety of issues that this nation must face, which will affect every single American."

Internists also agree with many of the President's proposals to achieve universal access, even though some of the elements of his plan have raised questions or concerns. Where we disagree, our delegates voted to come to the table with constructive alternatives in an effort to bridge our differences. There are also elements of some of the other proposals that are being considered by Congress that have merit and should be included in the final legislation reported out by Congress. ASIM believes that comprehensive reform should include the best elements of each of the proposals that are being considered by Congress, rather limiting consideration to only one approach.

The Clinton plan: Key Elements that Internists Support

ASIM's House of Delegates endorsed many of the key elements of the President's proposal, at least as they were outlined in the draft plan. ASIM is in general agreement with the following key elements of the President's proposal:

1. Mandating that employers and employees contribute to the costs of purchasing health insurance. ASIM believes that it is essential that all individuals be guaranteed access to a standard benefits package. Of the options for accomplishing this—a mandate that employers contribute to coverage, a mandate that individuals purchase coverage, or automatically enrolling individuals in a single payer system—an employer mandate would be the easiest to implement, since it builds upon the existing job-based system of health insurance coverage. We strongly support providing generous subsidies to small businesses, based on their average payroll cost, to ease the burden of complying with this requirement.

2. Mandating competition between accountable health plans (AHPs), each of which should be required to offer a standard benefits package and agree to non-discriminatory marketing and premiums. ASIM believes that market-based competition between health plans offers the best approach to controlling costs, since it empowers individuals to determine how much they wish to spend on their health care. The requirements that all plans provide a standard benefits package, not vary their premiums based on risk or engage in discriminatory marketing and underwriting practices are essential to assure that all plans compete on a level playing field, that individuals not be subjected to being under-insured, and that individuals are not excluded from coverage or charged exorbitant rates because of health status.

3. Emphasizing preventive and primary care services in the standard benefits package. ASIM believes that coverage for well baby care, periodic adult physical examinations, immunizations, and regular screening tests will greatly expand access to proven clinically-effective preventive services. We will be reviewing the benefits package in detail and making additional recommendations, based on how it compares with a standard benefits package developed by the American Medical Association Council on Medical Service (AMA-CMS) that our House of Delegates has endorsed. ASIM is concerned that the coverage for mental health benefits in the President's plan is more restrictive than the AMA-CMS recommendations.

4. Improving payments for primary care services and redirecting Graduate Medical Education funding to increase the number and proportion of physicians trained in primary care. Earlier this year, ASIM issued a white paper titled "Rebuilding Primary Care: A Blueprint for the Future." We are pleased that 18 of the 44 recommendations in the paper are included in the President's plan, including:

- Basing Medicare payments for practice costs on resource costs, not historical charges.
- Creating a separate and higher volume performance standard for primary care services.
- Raising Medicare bonus payments from 10 to 20 percent for primary care services provided in designated health shortage areas.
- Streamlining Medicare administrative and review requirements (nine specific ways of streamlining Medicare are presented in the reform proposal).
- Easing CLIA requirements for office-based physicians.

- Developing a uniform claims form and technologies to facilitate transfer of patient information, with protections to preserve confidentiality, and uniform requirements for electronic billing by all insurers.
- Requiring all health plans to meet federal guidelines on their utilization management and claims procedures.
- Requiring all health plans to divulge their protocols for controlling utilization and costs, including utilization review criteria.
- Providing for a wide variety of health plans, including plans that allow free choice of physician, to compete.
- Requiring all health plans to offer improved coverage and lower deductibles for primary care and preventive services.
- Expanding Medicare coverage to clinically-effective preventive services, including periodic health examinations.
- Providing substantially greater Medicare funding for primary care residency programs, with the goal of moving toward a system in which 50 percent of physicians complete a training program in internal medicine, family practice and pediatrics and that enter and remain in primary care. ASIM believes that the 50:50 ratio of generalist to specialists should be viewed only as a goal, not an absolute requirement. There should be flexibility for a national workforce commission to recommend policies that vary from this goal, provided that they would result in a substantial increase in the number and proportion of physicians trained in primary care.
- Establishing a national loan forgiveness program for physicians who enter and remain in primary care practice for a defined period of time.
- Increasing support for training in ambulatory settings, including increased support for training in Area Health Education Centers and community health centers.
- Requiring all-payers to contribute to a pool to support residency programs that meet policy goals relating to supply, specialty mix, and site of training.
- Expanding support for the National Health Services Corps.
- Providing a non-refundable personal tax credit for physicians who practice in rural areas with a shortage of health professionals and excluding NHSC loans from gross income for tax purposes.
- Increasing research in primary care, health services delivery and outcomes, as well as for the development of research faculty in the primary care disciplines.

We are also pleased that the plan includes proposals to increase Medicare payments for office visits and other undervalued primary care services. Although ASIM agrees with the objective of increasing overall payments for these services, we have some specific concerns and recommendations on the proposals to increase the relative value units (RVUs) for office visits. We believe that it would be preferable to make the required improvements in payment through a separate adjustment factor for primary care visit services, rather than through changes in the RVUs. ASIM also has concerns about lowering the RVUs for office consultations in order to increase the RVUs for office visits. We have submitted detailed recommendations to the administration on how payments for visits can be increased without being in conflict with the goal of basing payments on objective measures of resource costs.

The President's proposals include more initiatives to rebuild primary care—a key litmus test for ASIM's support of health system reform legislation—than any of the other legislative proposals. It is essential that these and other measures to rebuild primary care be included in any legislative package ultimately adopted by Congress.

As Congress considers measures to rebuild primary care, including those proposed by the President, it is essential that it fully address the disincentives created by existing governmental policies for physicians to enter, and remain in, primary care practice. Inequitable levels of Medicare payments, excessive red tape, unnecessary regulatory programs, and other

governmental policies have created an environment that is hostile to primary care practice. ASIM believes that Congress must ease the regulatory burdens on primary care physicians, reduce paperwork and micromanaging, and assure that health system reform does not create new bureaucratic burdens or payment inequities that are in conflict with the objective of rebuilding primary care.

5. Streamlining Medicare red tape, simplifying billing requirements, mandating regulatory relief, and requiring health plans to divulge utilization and credentialing requirements and to meet other federal standards governing their review methods. The changes in Medicare procedures proposed by the administration address many of the hassles commonly experienced by internists and their patients in dealing with Medicare. Uniform claims forms and the development of other technologies to facilitate exchange of information can also ease the hassle factor for physicians and patients. Because many of the accountable health plans will be "managed care" plans that will have strong incentives to limit access to services, ASIM believes that it is essential that they be required to divulge the criteria used in determining coverage for services, that each plan be required to establish a provider advisory panel and respond to concerns that it raises, and that plans be required to meet federal guidelines to reduce unnecessary, duplicative or conflicting review requirements. Easing CLIA requirements for office laboratories is also welcome.

During ASIM's annual meeting, it was apparent that many internists are concerned that despite these efforts to ease hassles and red tape, other aspects of the President's plan may increase bureaucratic intrusion into medical care. They are concerned about the broad authority given to the national board and the health alliances, and are concerned that health plans may respond to constraints placed on their premiums by micromanaging physicians and/or by unfairly and arbitrarily excluding physicians from participation. ASIM has some specific recommendations relating to the authority of the national board and health alliances, as discussed later in this statement, that would reduce the possibility that they may engender further bureaucratic intrusion into medical practice. We also intend to provide Congress with specific recommendations for federal legislation governing the credentialing, selective contracting, and utilization review requirements of health plans, to assure that patients and physicians have due process rights to challenge practices by health plans that would compromise patient care.

6. Establishing health alliances or purchasing cooperatives for small businesses. ASIM agrees that small business participation in purchasing groups or health alliances can give them needed collective clout in getting the best deal from competing healths. As I will discuss later in this statement, ASIM believes that some changes in the composition, requirements for participation, and authority of the health alliances are needed.

7. Requiring all plans to include requirements that individuals contribute to the cost of their care. ASIM agrees with the President that all plans should charge appropriate copayments and deductibles for all services. In order to control costs, individuals must have a financial stake in the care that is provided to them. The three levels of cost-sharing in the President's proposal appear to be reasonable, with the exception of the 40 percent copayment for individuals who receive care on a "point of service" basis from a physician or other "provider" outside a health plan's network. Although we believe that somewhat higher copayment for the point of service option is appropriate, we believe that the 40 percent copayment may be too punitively high for many Americans.

8. Financing health system reform in part through higher taxes on tobacco. ASIM strongly supports increasing taxes on tobacco and other products that are harmful to health, both as a means of offsetting the health care costs created by use or misuse of these products and as a means of reducing consumption of products shown to be detrimental health. As explained later in this statement, ASIM believes that it would be appropriate for Congress to consider levying even higher taxes on tobacco products and raising the taxes on other products, such as alcoholic beverages.

Each of these elements of the Clinton plan provides a solid framework for a comprehensive bill to guarantee universal access to a standard benefits package at an affordable cost. ASIM urges Congress to enact a reform proposal that is consistent with each of these elements. Although a few of these key elements are controversial—there is considerable disagreement in the business community on the employer mandate, and the incentives for primary care have generated considerable controversy within medicine—ASIM is struck by how much agreement there is on most of the elements I've just described. The President's plan shares with the Managed Competition bill (H.R. 3222) and the Senate Republican Health Task Force proposal such elements as the formation of purchasing groups or health alliances (although there are differences on the size, mandatory nature, and authority of those groups), competition between accountable

health plans, standard benefits packages, insurance market reforms (also included in H.R. 3080, the proposal introduced by the House Minority Leader's Health Care Task Force), and increases in "sin" taxes. ASIM also believes that individuals should have the option of establishing a tax free medical savings account, instead of enrolling in an accountable health plan. H.R. 3080 and a bill recently introduced by Senator Phil Gramm include provisions to authorized medical savings accounts.

This is not to gloss over the substantial areas of disagreement between the different legislative proposals, but to illustrate that there are also considerable areas of congruence that tend to get overlooked in all of the focus on the areas of conflict.

Choice, Liability reform, and anti-trust

There are three areas of the President's plan that ASIM believes are a good start in including reforms that are important to internists—guaranteeing choice of physician, making reforms in the medical liability system, and providing limited anti-trust protection to physicians—but where further improvements are needed. Specifically:

1. The President's proposal to require that individuals have access to plans that offer choice of physician should be expanded and improved by:

- **Requiring all accountable health plans to offer a "point of service" option for individuals to obtain care outside of the plan's "provider" network, subject to higher cost-sharing requirements (the amount of which would be limited by law).**
- **Eliminating any authority for health alliances to waive the requirement that a fee-for-service plan be offered or to limit the number of fee-for-service plans that may participate.**
- **Replacing the requirement that physicians who participate in the FFS plan be paid on the basis of a fixed fee schedule with no balance billing, with a proposal to require "price transparency" in physician fees. Fixed fees would discourage physicians from participating, thus reducing free choice of physician under those plans.**
- **Requiring that health plans that selectively contract with physicians as independent contractors to provide services to enrollees must meet certain due process requirements before excluding willing physicians from participation or terminating such contracts.**

ASIM is pleased that the President and Mrs. Clinton have emphasized the importance of maintaining choice of physician. The requirements that individuals have access to a "fee-for-service" plan and a preferred provider plan (PPO) option that offers a "point of service" option is a good start. We are pleased that no restrictions would be placed on the number of plans that a physician may join.

The requirement that the FFS plan pay on the basis of a fee schedule negotiated with the health alliance that would preclude balance billing, with total expenditures limited by a global budget, would mean that the FFS plan would not truly offer free choice of any physician in the community, but only those who are willing to accept the fixed fee schedule. As has been amply shown by the Medicaid program, many physicians are unwilling or unable to participate in a plan that pays on the basis of a below-market-rates fixed fee schedule with no balance billing. For the FFS plan to truly be a "free choice" plan, access to any physician—not just those who are willing to accept the fee schedule—should be permitted. As an alternative to a fixed fee schedule, ASIM has developed a proposal that relies on "price transparency"—that is, creating a simple method for individuals to compare in advance of receiving services a plan's payment schedule for covered services with what each physician charges for those services—to promote price competition and to protect individuals from excessive out-of-pocket expenses. This would also avoid the "black market" that inevitably accompanies price controls.

ASIM specifically proposes that all plans and physicians that pay and bill on a fee-for-service basis—that is, plans with a "point-of-service" option and the FFS plan—be required to use an improved RBRVS, but not with the Medicare conversion factors. Each physician and health plan would select their own dollar multiplier for the approved RBRVS, which would then be provided to all enrollees. With this information, individuals would know in advance how each physician's own fee schedule compares with how much their plan allows. ASIM's approach would not only protect patients from excessive charges, but introduce competition in physician fees that will lower overall costs. Noted Princeton health economist Uwe Reinhardt supports ASIM's competitive pricing

approach, saying that "The high price transparency alone probably would drive health care prices toward greater uniformity and acceptable levels, without explicit rate regulation." Business Week magazine hailed ASIM's "novel approach" as a viable alternative to price controls.

Finally, the President's plan would allow health plans, except for the FFS plan that must accept "any willing provider" (i.e. a provider that accepts the fixed fee schedule), to limit the number of physicians who could participate. ASIM supports federal preemption of state laws that restrict the ability of health plans to contract selectively for services, provided that they meet federal standards to mandate that physicians be given certain due process rights if they are excluded from participation or their contracts are terminated. Such federal protections are necessary to prevent patients from having their choice of physician unfairly abridged by a plan that arbitrarily excludes their doctor from participation. ASIM will be providing detailed recommendations for federal legislation to govern selective contracting by health plans.

Because choice of physician is so important to continuity of care and the doctor-patient relationship, however, ASIM believes that additional protections need to be included. The President's draft proposal would have allowed health alliances to waive the FFS requirement if a plan is not financially viable, if it charges 20 percent more than the average premium, or if enrollment in the plan is inadequate. The proposal also permitted health alliances to offer only one FFS plan if they so choose, even though others may wish to enter the market. We are encouraged that the administration has recently indicated that it may make changes in its proposal to limit the authority of the health alliances to exclude plans or to limit the number of plans that will be permitted to participate. ASIM believes that Congress must assure that there are no limits on the number of FFS plans that may participate, so that any plan that wishes to enter the market, and that meets the insurance market standards and basic benefits required of an AHP, is permitted to compete.

2. The President's proposals for medical liability reform should be expanded to include a cap on non-economic damages and a "sliding scale" limit on contingency fees.

ASIM appreciates the President's recognition of the problems created by the current liability system, and his good faith effort to make improvements. The lack of a cap on non-economic damages, however, will mean that the reforms will fall considerably short of what are required. Further, although President Clinton proposes an absolute limit on contingency fees, ASIM believes that this limit is not likely to be effective unless it is changed to a "sliding scale" limit, based on the size of the award, on attorney's fees. ASIM's proposed additions are currently in place in California, which has achieved considerable success in moderating the costs of the medical liability system. The Managed Competition Act of 1993, and the Senate and House Republican proposals, all include these additional, necessary reforms. ASIM also believes that federal legislation should not pre-empt state laws that impose more stringent restraints on non-economic awards and contingency fees.

3. The proposal for creation of "safe harbors" for physicians to negotiate with health plans and alliances is a step in the right direction, but further relief is needed.

To avoid having a health care system that is controlled by hospitals, insurers, and health alliances, physicians must have the ability to advocate the interests of their patients by negotiating fees and working conditions with health plans, and to form their own networks to compete with those organized by insurers and hospitals. The President has recognized the importance of giving physicians the ability to organize and negotiate without running afoul of anti-trust restrictions, by proposing certain "safe harbors" for protected conduct. These "safe harbors", however, are too narrowly defined. ASIM supports the proposals by the American Medical Association for additional protection from anti-trust to allow physicians to negotiate with health plans and to form their own competing groups.

Global Budgets and the National Board and Health Alliances

The single largest area of concern that ASIM has with the President's proposal is the proposed cap on overall health care expenditures and the related issue of how much authority the national board and the health alliances should have to set rates and regulate premiums. ASIM's concerns are shared by many, including members of the President's own party, such as those who have co-sponsored the Managed Competition Act of 1993, several prominent health economists, and business and insurer representatives.

ASIM believes, however, that the issues of global budgets and the authority of the national board and health alliances should be approached in a manner that attempts to find some common ground, if possible, rather than being an issue that polarizes the debate from the outset. One way

to avoid having the issue become a source of polarization is for groups, such as ASIM, that have concerns about the President's proposal to identify a constructive alternative.

The issue is not one of whether or not policies to restrain the increase in health care cost are required—they clearly are—but what kinds of policies are appropriate. ASIM believes that managed market competition between health plans, as proposed in the President's plan, the Managed Competition Act of 1993, and the Senate Republican Health Task Force, can bring down health care cost increases to an acceptable level, without requiring an overall cap on expenditures or controls over health plan premiums.

ASIM recognizes, however, that there is merit in having a process for reaching agreement on spending targets against which market performance can be compared, and for initiating a deliberative process to reach agreement on targeted cost controls should market forces be unable to keep cost increases to the agreed-upon level. ASIM believes that consideration should be given to an alternative that includes the following elements:

- 1. Instead of a fixed, formula-driven cap on overall spending, as the president proposes, ASIM favors negotiations among physicians, payers, consumers and other stakeholders on a realistic and achievable rate of spending growth. Independent arbitration should be available to set the goals if agreement is not achievable.**

Because they would have a voice in setting the target, each of the parties to the agreement would be committed to doing everything possible to keep spending within the target. By contrast, if a cap is imposed based on an arbitrary and probably unrealistic formula, those who are really needed to make it work (physicians, hospitals, consumers and other stakeholders) are not likely to feel any commitment to keeping spending within the cap.

Further, a negotiated spending target would have the virtue of being flexible—if the target were exceeded, all of the stakeholders would have a voice in determining how to respond. If their analysis showed that the target was unrealistic in the first place, it could be revised. Alternatively, the stakeholders might agree that the target was realistic and that the cost overruns were in fact due to inefficient and costly behavior. They would then try to reach agreement on targeted interventions—such as controls over utilization of certain procedures or selective fee restraints—to keep future spending within the target, or submit to arbitration. A global budget cap, by contrast, would immediately trigger controls over prices if the global budget were exceeded.

The New York Times agrees: "Mr. Clinton could agree to loosen the premium caps. Even better, he could turn the caps into targets; if a premium rose above the target, purchasing cooperatives would be required to diagnose the cause before proposing action."

ASIM's approach is a needed middle ground between those who argue against global budgets in any form and those who believe that an overall limit on expenditures is essential. The ASIM alternative places the emphasis where it belongs: introducing the incentives needed to bring true competition (and the improved efficiency it will bring) into the system. But it also recognizes the value of reaching agreement on credible spending targets against which the performance of the market can be assessed—but without the disadvantages of fixed, formula-driven caps.

- 2. A national board with adequate physician representation should be created to recommend updates in the benefits package and to convene negotiations on spending targets.**

President Clinton's proposal calls for the establishment of a Presidentially-appointed board that would have broad authority to enforce a cap on overall spending and to set other rules for the reformed health care system. ASIM believes that the board should have more limited authority, such as that specified by the Managed Competition Act of 1993. Further, ASIM believes that it is essential that practicing physicians be represented on the board. Although ASIM believes that the board should not determine or enforce an overall cap on spending, it should have authority for convening negotiations on spending targets and promulgating and monitoring compliance with the targets, as described above.

- 3. Market competition between health plans should be enhanced by capping the amount of the employer's contribution to purchasing health insurance that can be deducted as a business expense and that is tax free income to the employee. The cap should be established at a level that does not unfairly disadvantage plans that offer choice of physician.**

A cap on the amount of an employer's contribution to the purchase of health insurance coverage is a feature of the Managed Competition Act of 1993 and the Senate Republican Health Task Force proposal. Unlike those proposals, which would unfairly disadvantage FFS plans that offered free choice of physician by setting the cap at the premiums of the lowest bidding plans, ASIM believes that the cap should be set at the average or median premium of competing plans. A tax cap would introduce much greater price sensitivity into the system, thus helping to slow the escalation in health care costs. Plans that raised their premiums to an amount that is considerably above the cap would be at a market disadvantage, which would act as an incentive for plans to restrain premium increases. Regulation of health plan premiums would not be necessary if the tax cap introduced market forces that would restrain premium increases.

4. Health plans and physicians should be required to establish their payment and charge schedules in a manner that allows for 'price transparency', as described earlier in this statement, rather than mandating a fixed fee schedule.

ASIM's competitive pricing proposal would introduce price competition and protect individuals from excessive charges, without the necessity of direct price controls.

This alternative has been developed in the hope that it can lead to further constructive discussions among the administration, members of Congress, and physicians on a possible way to achieve agreement on a predictable rate of increase in health care spending, without the disadvantages many see with formula-driven expenditure caps and price controls. We hope to move the debate away from the "either/or" question of whether or not expenditures should be capped, to consideration of possible alternatives. We welcome the opportunity to discuss our ideas further.

Finally, ASIM supports the creation of health alliances, as called for in the President's plan, but believes that they should not be authorized to regulate health plan premiums, to limit the number of FFS health plans that could be offered, or to restrict plans whose premiums are more than 20 percent of the average. Rather, ASIM believes that the health alliances can play a useful role in giving small employers the collective market power previously available only to large employers, and in certifying that the AHPs meet the requirements for participation on a level playing field. We also believe that mandatory participation should be limited to smaller employers—e.g. those with 1000 or fewer employees—than the President's plan calls for. Finally, ASIM believes that Congress should examine the proposal to structure health alliances within state boundaries, since this could disrupt natural markets and referral patterns in many regions that cross state boundaries.

Financing Health system reform

ASIM supports the President's proposals to finance health system reform by increasing taxes on tobacco products and by requiring all employers to contribute to the cost of purchasing health insurances. Internists are concerned, however, about the proposed cuts in Medicare that are required in the President's plan, and that are also required to a somewhat lesser extent in several of the other legislative proposals. We are not persuaded that these cuts can be achieved without compromising patient care. Many internists have already reported that they are unable to accept new Medicare patients because of low levels of payment. Even though the administration proposes to exempt some primary care services from the reductions, some of the proposed cuts—such as a requirement that all laboratory services be awarded on a competitive bidding basis, which would eliminate virtually all physician office labs—would be highly detrimental to internists. Even though some of the money saved in Medicare would be used to finance prescription drug benefits and long-term care, it doesn't make sense to pay for new expanded Medicare benefits by making cuts that may limit access to other services already covered by Medicare.

As an alternative to further cuts in Medicare, ASIM favors raising the proposed tax on tobacco by a greater amount than that proposed by President Clinton, increasing taxes on alcoholic beverages, capping the deductibility of employer contributions to the purchase of health insurance, and only if necessary, increasing personal and payroll taxes.

Conclusion

ASIM expects to have additional recommendations to offer on many other aspects of the President's plan and on the other proposals in Congress. We will be reviewing in detail the actual legislative language of the President's bill as soon as it is available.

We commend President Clinton for what he has accomplished so far, and reiterate our willingness to work with the administration, Congress, and others to achieve enactment of legislation to bring about comprehensive health system reform. ASIM for its part will do everything it can to reduce

the negativism that threatens to undermine the fragile consensus for reform by emphasizing those proposals in the President's plan—as well as in the other proposals in Congress—that we support, and by offering constructive alternatives to those proposals that we do not support, rather than just standing in opposition. ASIM believes that it is time to put an end to “just say no” politics and begin the task of working together to identify the key elements that command substantial support and to iron out our differences on the others.

Chairman STARK. You think the tax limits will work. How do you square that with the fact that 80 percent at least of the Medicare beneficiaries pay for medigap insurance with after-tax dollars? It doesn't slow them down. Why would it slow anybody else down?

Dr. NELSON. I am not so sure that you can extend the Medicare experience across the entire universe, Mr. Chairman. But I think that it certainly has the potential to raise some revenue that are needed—that is needed to expand coverage. And, until we try a tax cap, I don't know how we can say it won't work.

Chairman STARK. We have it on Medicare. It doesn't do anything.

Dr. NELSON. It is not at the median level.

Chairman STARK. I beg pardon?

Dr. NELSON. It is not at the median level, as a tax cap would be among competing health systems or health plans.

Chairman STARK. Fine, fine. If you want any treatment above the Medicare level, you have to pay for the insurance out of your own pocket with after-tax dollars or pay for it out of your own pocket. What is different about a tax cap under these other plans?

Dr. NELSON. I understand that. But I am saying it is not placed at the median premium level among competing plans with an opportunity to select from other plans. Buying medigap insurance isn't the same.

Chairman STARK. Interesting. Dr. Carey.

**STATEMENT OF WILLIAM D. CAREY, M.D., PRESIDENT,
AMERICAN COLLEGE OF GASTROENTEROLOGY, ON BEHALF
OF THE GASTROENTEROLOGY LEADERSHIP COUNCIL**

Dr. CAREY. Mr. Chairman and committee members, I am William Carey, and I appear here today on behalf of the Gastroenterology Leadership Council. The GLC is a working coalition representing over 10,000 GI specialists. I currently practice at the Cleveland Clinic.

Earlier this month, we had the honor of having Chairman Stark address our 1993 annual meeting in New York. Mr. Chairman, the GI specialists who heard you speak appreciate your taking your valuable time to spend time with us to learn more about gastroenterology issues and the concern of our patients.

Today, I will focus on three particular issues: Colorectal cancer screening, assuring quality care, and Medicare funding issues.

Colorectal cancer is the second most frequent cancer killer in America, claiming the lives of more than 57,000 people annually, far more than either breast or prostate cancer. The overall morality rate for colorectal cancer cases approaches 60 percent. Detection of early lesions unquestionably saves lives.

Today, Medicare patients do not enjoy any colorectal cancer screening benefits, nor are any currently included in the standard benefits package under President Clinton's health care reform proposal. The OTA, the American Cancer Society, and the National Cancer Institute all agree we should provide colorectal screening. Legislation such as Chairman Stark's bill and the Republican Task Force bill include these benefits.

We specifically request that any standard benefit package should include coverage for annual fecal occult blood testing and flexible

sigmoidoscopy every 3 to 5 years as the two general screening mechanisms of choice for patients over 50 who have no other predisposing factor for colorectal cancer. These two tests are inseparably linked.

Additionally, for patients who have recognized risk factors for colorectal cancer, it is essential that the benefit package provide colonoscopy surveillance for these high-risk patients.

There has been a rapid proliferation in the use of medical technology, including GI endoscopy, by medical and surgical specialists. There is growing concern that the proliferation of new technology may be outpacing adequate physician training.

The GLC favors a system which would link reimbursement for GI procedures to credentialing to perform a specific procedure. This would ensure the provision of the highest quality and appropriate care and limit costs by reducing the number of inappropriate procedures.

Finally, the GLC is deeply concerned that President Clinton and some legislators have proposed significant new Medicare reductions to pay for health care reform. Congress has just imposed nearly \$56 billion in cuts. And we think Congress should not accept the Clinton administration's additional \$124 billion in cuts because Medicare has not yet adjusted to the \$56 billion cuts. Additional cuts may adversely affect the quality of patient care.

In conclusion, as the specialists who most commonly treat patients with colorectal cancer, we urge Congress to include colorectal screening and surveillance by colonoscopy for high-risk patients in any benefit package as well as in the Medicare benefits package. We also urge the committee to address the issues of credentialing for quality and the significant problem of the President's proposal for \$124 billion in additional Medicare cuts.

I would be pleased to respond to Chairman Stark's question. We believe a system that allows for a choice among several plans will result in a system that is most likely to be competitive and affords the greatest chance of controlling costs. Medicare or alternative Federal programs should compete with private insurance programs.

Thank you. I would be glad to answer any questions.

Mr. McDERMOTT [presiding]. Thank you. We will hold our questions until we have heard the whole panel.

[The prepared statement follows:]

**WRITTEN STATEMENT OF THE
GASTROENTEROLOGY LEADERSHIP COUNCIL
TO THE WAYS & MEANS HEALTH SUBCOMMITTEE
ON
HEALTH CARE REFORM**

October 26, 1993

I am Dr. William D. Carey, and I appear here today on behalf of the Gastroenterology Leadership Council. The GLC is a working coalition of scientific, educational organizations in the field of gastrointestinal conditions and diseases composed of the American Association for the Study of Liver Diseases (AASLD), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE). I also currently serve as President of the American College of Gastroenterology and practice at the Cleveland Clinic Foundation in Cleveland, Ohio.

Earlier this month, we had the honor of having Chairman Stark address our 1993 Annual Meeting in New York City. Mr. Chairman, as you know from that occasion, gastrointestinal specialists have many questions and concerns regarding health care reform. All of the approximately 2,000 GI specialists who heard your address were extremely impressed with the breadth of your knowledge of medical and health care delivery issues. We sincerely appreciate your taking that valuable time to better understand more about gastrointestinal specialists and their patients with digestive conditions.

The GLC believes that our current health care system requires fundamental change to assure that **all** individuals have access to affordable and appropriate health care services. However, any successful reform effort must include the following items to assure success.

COLORECTAL CANCER SCREENING

Colorectal cancer is the second most frequent cancer killer in America, claiming the lives of 57,000 persons annually—far more than either breast or prostate cancers. The overall mortality rate for all colorectal cancer cases approaches 60%; detection of early lesions results in a mortality rate of 20% or less. The stark reality is that too many of these cancers go undetected until they are past the curable stage. To achieve improvement in survival, it is clear that improvement in the early detection of malignant lesions and their removal must occur. Preventive care and early detection are of paramount importance in improving survival prospects and providing cost-effective care.

Today, Medicare patients do not enjoy any colorectal cancer screening benefits, and these benefits are not currently included in the standard benefits package under President Clinton's health care reform proposal. The Office of Technology Assessment (OTA) has said that colorectal cancer screening "should produce dividends both in terms of additional years of life and savings in health care costs." The American Cancer Society and the National Cancer Institute have instituted guidelines for fecal occult blood testing and flexible sigmoidoscopy that have been accepted by the Congress in legislation such as Chairman Stark's bill, H.R. 200 and the House Republican Health Care Reform bill, H.R. 3080. For these reasons, we believe this benefit should be available to both the general and Medicare populations.

In patients at higher risk for colorectal cancer by virtue of family history, chronic inflammatory bowel disease or prior cancerous or pre-cancerous lesions, surveillance colonoscopy usually is medically appropriate. We would recommend including this screening tool in the benefits package as well for this category of patients already recognized at high risk.

We specifically request that any standard basic benefit package should include coverage for:

- ☐ **annual fecal occult blood testing, AND**
- ☐ **flexible sigmoidoscopy every 3-5 years,**

as the two general screening mechanisms of choice for asymptomatic patients over 50 years of age who have no other predisposing factors. **These two tests are inseparably linked—together they will provide a valuable first line of defense against colorectal cancer, but neither will be effective unless provided in tandem with the other.** Additionally, for the asymptomatic patient who by virtue of family history, prior experience of cancer or its precursor neoplastic polyps, or chronic history with a digestive disease condition or other predisposing factor, faces a significantly higher risk for the disease, it is essential that the benefit package provide:

- ☐ **colonoscopy surveillance for these high risk patients.**

Until both Medicare and our national health care standard benefits package begin to provide benefits that will encourage early detection and treatment, we stand little chance of markedly reducing the devastating impact and fatality rates of our Nation's #2 cancer killer, colorectal cancer.

THE PATIENT'S PERSPECTIVE

Gastrointestinal subspecialists are not alone in the plea for inclusion of colorectal cancer screening in both the Medicare program and the standard basic benefit package. Patients with digestive diseases are also urging that priority attention be given to colorectal cancer. The Crohn's and Colitis Foundation of America, a national patient/health consumer organization with 72 chapters and 113,000 members nationwide has stated,

"CCFA recommends the inclusion of colonoscopic colorectal cancer screening, as well as flexible sigmoidoscopy, as options for the asymptomatic patient who has a predisposition toward colorectal cancer, in any national standard benefit package; as well as the assurance that these procedures are reimbursable under Medicare."

The Digestive Disease National Coalition, a patient-oriented confederation of twenty-one different patient advocacy, health consumer and professional organizations, states, "DDNC supports federal health care reform legislation and policy that would provide coverage for periodic screening of beneficiaries for colorectal cancer." They have endorsed the following framework for appropriate screening benefits:

"For those persons who do not display symptoms it is recommended that a digital rectal examination be performed periodically beginning at age 40.

"For those persons who do not display symptoms it is recommended that fecal occult blood testing be performed annually, beginning at age 50.

"For those persons who do not display symptoms, it is recommended that a flexible sigmoidoscopy be performed at suitable intervals, beginning at age 50.

"Persons at high risk for colorectal cancer because of family history or pre-existing disorders should have earlier and more intensive surveillance, most commonly requiring periodic colonoscopy."

ASSURING ACCESS FOR CHRONICALLY ILL AND THE DISABLED

The new system of health care must assure appropriate access for all, including the chronically ill and disabled. Currently, many insurance companies avoid patients with chronic illness and functional disability, such as Crohn's disease, ulcerative colitis, liver disease or functional diseases such as irritable bowel syndrome, rather than encouraging cost effective care for these patients.

Systems of care must ensure that persons with multiple chronic illnesses or severe disability receive adequate, integrated, and appropriate care that meets their needs. Appropriately adjusted premiums and reimbursements for the most severe cases would encourage appropriate care of these patients, reversing past discriminatory patterns of avoidance by insurers.

ENCOURAGING APPROPRIATE USE OF SPECIALISTS

The system of care should encourage appropriate use of specialists and payments to providers (either per capita or fee for service) and must reflect complexity of illness not only for acute illness, but also for the chronically ill and functionally disabled. While many believe that our current health care system relies too heavily on specialists, ignoring the contributions of specialists would be equally devastating to the quality of care provided.

Any system of care should maximize flexibility for patients to select primary care providers and specialist/subspecialist providers. The Gastroenterology Leadership Council believes that early consultation/intervention of a specialist often eliminates costly and unnecessary errors and complications, eliminates duplicative procedures, and assures accurate diagnosis and the timely delivery of care. This approach provides more accurate and cost effective diagnosis and saves time for both the patient and the payor.

Many digestive diseases are complex and/or chronic. In these cases, specialists in digestive diseases are often the appropriate managers of these illnesses. Reimbursement policies should not discourage cost-effective patient care partnerships by putting the primary care physician at financial risk when consulting specialists, or the specialist at risk for accepting responsibility for care of complex patients.

For continuing care of chronic and/or complex illnesses, reimbursement policies should compensate only the physician managing the patient's care. Health plans should avoid duplicative payments.

Persons with disabilities often require frequent services, prolonged visits, and expensive medication regimens. Current reimbursement rates, both fee-for-service and capitated rates, discourage caring for the most difficult cases. The care needs of patients with severe or chronic illness may place an overwhelming financial risk on the specialist who is subcapitated by a capitated primary care "gatekeeper" to provide such care.

MEDICAL LIABILITY

Our current inefficient, costly and inequitable medical liability problem is best addressed by improving the quality of care provided and reducing both negligence and defensive medicine. This is accomplished by streamlining the awards process and improving physicians' ongoing training. Extensive research by the Department of Health and Human Services, the Justice Department, the General Accounting Office, the National Academy of Sciences, the Rand Corporation and the Harvard School of Public Health have shown that our current system does not compensate victims of medical injury equitably. Those studies also show that medical liability cases do not identify the incompetent physicians in the community since claims against physicians overwhelmingly fail to correspond with the occurrence of a negligent adverse event.

The GLC believes that all licensed professionals should be required to participate in continuing medical education and recertification. Those who do not participate should not be allowed to practice. The medical liability system should be reformed further to establish uniform standards for medical liability claims that include periodic payment of future damages for large awards, limited non-economic damages and legal fees, a statute of limitations with a special exception for children under 6 and limited liability based on the percentage of damages caused by the various parties.

TRAINING, CREDENTIALLING AND REIMBURSEMENT

Credentialling should be improved to ensure that physicians are adequately trained for the specialized services they offer. There has been a rapid proliferation in the use of GI endoscopy by many medical and surgical specialists. It is increasingly important to assure that physicians attain proficiency in each of the endoscopic procedures they perform. There is growing concern that the proliferation of this new technology may be outpacing sufficient physician training.

The recent experience of New York State with laparoscopic cholecystectomy has led to legislation limiting physicians' use of this technique, unless they can document appropriate training. Further, the State of Florida's medical board recently set practice standards for certain procedures, including colonoscopy. In order to assure that physicians have a demonstrated competency, we believe that each physician needs to be credentialed in the procedures they perform. Currently, credentialing is handled through the hospital, but in a new health care system, other agencies could play a role. The GLC favors a system that would link reimbursement for GI procedures to credentialing to perform a specific procedure. This would assure the provision of the highest quality and appropriate care, and limit costs by reducing the number of inappropriate procedures.

ANTI-TRUST

Physicians must be given relief from anti-trust prosecution when they act to protect patients from unethical or incompetent practitioners and when in negotiations with purchasing cooperatives and health plans. Many suits have been brought against physicians that collectively, through the established peer review process, have found a colleague lacking in "physician stature." The threat of suit has reduced physician participation in this process even in those areas where the cases were thrown out of court.

Second, managed care settings provide protection from anti-trust suits when unethical or incompetent physicians are identified by other members of the managed care plan. Further strengthening of this aspect of managed care could increase physicians' willingness to participate in these settings.

Third, physicians should be allowed to provide collective information on medical review criteria, quality assurance programs, coverage, medical policy and innovative reimbursement formulas that improve the quality and efficiency of care. Further, physicians should be able to join together in negotiations with purchasing cooperatives and health plans and in discussions of fees that will accommodate payer cost saving initiatives.

Finally, all participants in managed care system negotiations should have financial and other information available to assure fair and fruitful negotiations.

GRADUATE MEDICAL EDUCATION

The GLC believes that cuts in medical education payments designed to reduce the supply of specialists and increase the supply of generalists have been ineffective. Physician supply should be adjusted by adopting the recommendations proposed by the Physician Payment Review Commission. Initial attempts to change the physician supply through adjusting graduate medical education payments have not succeeded. The Medicare direct graduate medical education policy changes from 1986 have not changed the specialty distribution of physicians-in-training.

The Physician Payment Review Commission has recommended in its 1993 Annual Report to Congress, and we strongly support, a three-tiered approach to preparing our physician supply in the 21st Century that assures quality programs for all specialties, including primary care. First, Congress sets the overall target for residency slots. Second, a commission of knowledgeable members sets the number of residency slots per specialty. Finally, boards that review the quality of programs such as Residency Review Committees, the currently existing entities that assure the quality of medical education programs, assign residency slots to the appropriate programs. Such assignment should be based solely on quality of education provided.

Until enactment of universal health coverage, payments should be made to hospitals that lose residents, but serve special functions in the community, such as providing a significant portion of indigent care. It is critically important to enact these proposals in their entirety.

The Physician Payment Review Commission has also recommended that all payors support graduate medical education through a fixed, mandatory 1% set-aside. We support this recommendation as well.

OUTCOMES RESEARCH

The federal government must increase its commitment to outcomes research, as well as the facilitation, support and dissemination of practice guidelines to improve the quality and efficiency of health care. Many studies have shown wide variation in practice patterns throughout the country and that the variation does not stem entirely from typical health risk variables, such as age, sex, race, income and mortality rates.

Currently, physicians are unsuccessful in obtaining independent information on cost-effectiveness to compare with the information provided by medical industry manufacturers. Health care reform offers an opportunity to develop information that considers all points of view on a product's efficiency and effectiveness.

To facilitate this process, all payors should contribute to outcomes research efforts, and the results of those efforts should be made available through a central database. The Agency for Health Care Policy and Research (AHCPR) could establish a central database for technology assessment information to help practicing physicians decide which technologies best fit patient needs. Electronic communications can make this information instantly available to physicians and patients.

Access to cost-effective technology should not be arbitrarily limited. Practice parameter efforts should strive toward **one** uniform standard of care that is reached through the involvement of disparate, but legitimate interests.

SUPPORTING CLINICAL RESEARCH

Appropriate and necessary patient care costs should be covered by health care plans for patients receiving standard treatment and patients involved in an approved investigational protocol. To keep new diagnosis and treatment modalities that prevent disease and save lives within the public's reach, **all** payors must support research.

The Institute of Medicine reported in 1988 that "[i]t is wholly inappropriate for third party payers to deny reimbursement for all appropriate and necessary patient care costs...**that would have been incurred in any case** simply because a patient is on an investigational protocol. Such denial would be tantamount to an abrogation of a contractual obligation." In addition, to assure the forward progress of medical treatments that save lives and improve therapies, third-party payers must continue to support the costs of patient care as part of research trials.

ELIMINATING THE "HASSLE FACTOR"

Unnecessary micromanagement and over-regulation of health care providers must end if system-wide costs are to be controlled. Bureaucratic paperwork must be reduced so that physicians can practice medicine, not push paper.

As the new Assistant Secretary for Health, Dr. Philip Lee, said in 1989, "[p]hysicians in the U.S. are now the most litigated against, second-guessed and paperwork-laden physicians in Western industrialized democracies." In addition, 69% of the physicians surveyed by the Physician Payment Review Commission for their 1993 Annual Report to Congress said they were very seriously concerned about paperwork and administrative hassles. This concern was expressed significantly more often than any other concern. Medicare and Medicaid topped the list as insurers that induced the largest amount of paperwork and hassles.

Any systems that result from health care reform must reduce the paperwork and hassles physicians currently face, not increase them. Further, any systems that result from health care reform must include a uniform billing process. Further, all health plans, whether they are fee-for-service, or managed care, must include physician input in developing standards of care, second opinion rules, and preauthorization rules so that they are consistent and effective.

MEDICARE

The Gastroenterology Leadership Council is deeply concerned that President Clinton has proposed significant new Medicare reductions to pay for health care reform. In August 1993, Congress passed an unprecedented \$55.8 billion in Medicare reductions to decrease the federal deficit. Congress should not accept the Clinton Administration's additional \$124 billion in cuts because (1) Medicare has not yet adjusted to the \$55.8 billion in cuts imposed under OBRA 1993, and (2) additional cuts adversely affect the quality of patient care. Health care reform should be accomplished in a manner that does not adversely impact the quality of patient care and maintains fairness in the system.

CONCLUSION

The Gastroenterology Leadership Council greatly appreciates the opportunity to present our interest in health care reform. As the specialists who most commonly treat patients with colorectal cancer, we urge Congress to include colorectal cancer screening by flexible sigmoidoscopy and fecal occult blood testing, and surveillance by colonoscopy for high risk patients, in any basic benefit package as well as Medicare benefits. We also strongly urge the Committee to address the issues of credentialing for quality and the significant problems of the proposal for \$124 billion in additional Medicare cuts when the President's is considered by this Committee. We would be pleased to respond to any questions which Committee members may have. Thank you.

Definitions:

Fecal occult blood testing - a simple chemical test performed on a stool smear to detect amounts of blood that are too small to be seen.

Flexible sigmoidoscopy - examination with a flexible instrument of the lower one-third of the colon within which 50-60% of polyps and cancers occur.

Colonoscopy - use of a longer flexible instrument capable of examining the entire large bowel. Colonoscopy is the most accurate method of examining the large bowel and has the additional advantage of allowing biopsy of suspected abnormalities and removal of most colorectal polyps which are the precursors of almost all colorectal cancers.

Screening - the use of a simple, inexpensive test applied to the average risk population designed to identify those individuals in that population more likely to have colorectal cancer.

Surveillance - Some individuals in the population have a high enough risk of colorectal cancer that periodic diagnostic evaluation is warranted. This process is referred to as surveillance.

Mr. McDERMOTT. Dr. Tinkelman.

**STATEMENT OF DAVID G. TINKELMAN, M.D., TREASURER,
JOINT COUNCIL OF ALLERGY AND IMMUNOLOGY**

Dr. TINKELMAN. Distinguished chairman and members of the subcommittee, my name is David Tinkelman, and I am a physician, board certified in pediatrics and in allergy and immunology. I appreciate the opportunity of appearing before you today on behalf of the Joint Council of Allergy and Immunology.

We are pleased to have been given the opportunity to evaluate and respond to the President and Mrs. Clinton's health care reform plan. We are very supportive of many aspects of the President's plan, including the guarantee of universal access, the prohibition of preexisting condition exclusions and the standard benefit package which bases coverage on medical need without arbitrary numerical limits on coverage.

However, we are concerned that the President's proposal would create an economic climate in which managed care may be the only economically viable model for providing care at the expense of fee-for-service medicine. We question whether, given the overall structure of the package, including premium regulation, budget targets and strict regulation of health care plans, fee-for-service medicine will be able to survive. We believe that using free market controls will keep the cost of premiums down, and it is important to preserve the individual choice and access to specialty care.

There are 12 million Americans with asthma. The prevalence and death rate of asthma are both increasing, particularly in the indigent and inner-city families who lack access to specialists. Total yearly expenditures associated with asthma exceed \$6 billion annually. These situations exist despite the fact that it has been documented that when patients receive necessary and timely care, which includes referral to the allergy immunology specialists, there are significant reductions in emergency room visits, hospitalizations and all associated costs.

It should be noted that the allergist/immunologist focuses on prevention of disease through education, environmental control, drugs and immunotherapy, which is allergy injections, when necessary, rather than simply managing symptoms.

This does not mean that there is no role for the primary care physician in treating asthma and allergic disease. One of the goals of health care reform should be the development of practice parameters and clinical guidelines to help primary care physicians effectively diagnose asthma and allergic diseases and know when to refer a patient. This will provide better, more cost-effective and accountable care.

We are extremely concerned about a practice now common among many HMO groups of rewarding gatekeeper physicians for withholding specialty care by means of direct incentive payments, excessive risk withholds and the like. This type of practice is not in the best interest of patient care and is contrary to the concepts of medicine to which we all ascribe. We believe any health care reform legislation must regulate this practice.

With respect to the Clinton proposal and physician work force, we view with alarm the presumption that American medicine will

be better off only if we increase the number of primary care physicians and decrease the number of specialists. We believe any such reductions should be undertaken only after careful study, with the specialists having extensive input.

We are pleased that the President recognizes the need for tort reform and are very supportive of some of his proposals. However, we would like to see reform in this area go further.

We are very happy that the President's plan includes reform of the antitrust areas. We believe reform in this area will be procompetitive and is essential in our specialty where the number of physicians is relatively small and in which mergers may result in market power and thus run the risk of antitrust enforcement.

In closing, we want to emphasize that we are very supportive of efforts by the President, the Congress and this subcommittee to enact meaningful health reform legislation. We believe it is critical that physicians play an active role in this process which will so greatly affect the profession.

Thank you.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

**TESTIMONY OF DAVID G. TINKELMAN, M.D.
JOINT COUNCIL OF ALLERGY AND IMMUNOLOGY**

Distinguished Chairman and Members of the Subcommittee, my name is David G. Tinkelman and I am a physician, Board certified in pediatrics and in allergy and immunology. I hold an academic appointment as Clinical Professor of Pediatrics at the Medical College of Georgia. I am also in private practice of allergy and immunology in Atlanta, Georgia. I appreciate the opportunity to appear before you today on behalf of the Joint Council of Allergy and Immunology to present our views on the President's Health Care Reform Proposal. I request that my full written statement be placed in the record.

The Joint Council of Allergy and Immunology is a professional, nonprofit organization that is sponsored by the American Academy of Allergy and Immunology and the American College of Allergy and Immunology. We represent over 4,000 clinicians and researchers in allergy and immunology, working to alleviate the suffering of the 35 million Americans with allergic and immune disorders.

We are pleased to have been given this opportunity to evaluate and respond to President and Mrs. Clinton's Health Care Reform Plan. In general, we feel that this plan represents a strong beginning to the needed reform of our health care system. We are very supportive of many aspects of the President's plan.

We support the guarantee of universal access and the prohibition on pre-existing condition exclusions. We are also very pleased with the contents of the standard benefit package which bases coverage on medical need without arbitrary numerical limits on coverage.

Access to Specialty Care

However, we are concerned that the President's proposal would create an economic climate in which managed care may be the only economically viable model for providing care at the expense of fee for service medicine. We believe it is important to preserve individual choice and access to specialty care.

There are 12 million Americans with asthma. The prevalence of asthma and the death rate due to asthma are both increasing especially among the indigent and inner-city families. Direct medical expenditures due to asthma are estimated at \$3.6 billion annually with indirect costs including lost wages accounting for an additional \$3 billion. Asthma is the most frequent cause for hospital admissions for chronic illness in children. Scientific studies of asthma care in this country demonstrate that when patients received necessary and timely care, which included referral to a specialist when appropriate, there were significant reductions in hospitalizations and emergency room visits as well as other associated costs. It should be noted that the allergist/immunologist focuses on prevention of allergic diseases through education, environmental controls, drugs, and allergy immunotherapy (injections) when necessary, rather than simply managing symptoms.

In two recently published studies, it was clearly demonstrated that those asthmatic patients referred to the allergist/immunologist had fewer lost school and work days, a better quality of life, and in one study, a 50% reduction in emergency room visits. Thus, proper specialty care can actually reduce costs, not to mention increasing quality of life. We believe this fact has been largely ignored in the current debate.

This does not mean that there is no role for the primary care physicians in treating asthma and allergic disease. We believe one of the goals of health care reform should be the development of practice parameters and clinical guidelines to help primary care physicians effectively diagnose asthma and allergic diseases, and know when to refer a patient for a work-up and treatment by a specialist. We have seen much unnecessary patient suffering because of ineffective treatment and/or delay in necessary referral to specialists. This has been associated with rising costs as well as increased emergency room visits and hospitalizations.

With this background in mind, we are opposed to any health care delivery model which creates inappropriate barriers to specialty care. We are not opposed to gatekeepers and managed care generally. However, we are concerned that in some cases, patients in managed care systems do not receive appropriate and timely access to specialty care. We would hope that as part of any health care reform package, managed care plans would be required to work with specialties to create effective, efficient systems of referral to decrease unnecessary costs and increase quality of care. We, as a specialty, would welcome the opportunity to work with the plans to develop appropriate referral practices for Americans with allergic, immunologic, and asthmatic diseases.

It should be noted that we are extremely concerned about a practice now common among HMOs of rewarding gatekeeper physicians for withholding specialty care by means of direct incentive payments, excessive risk withhold and the like. We believe this type of practice is not in the best interest of patient care and is contrary to the concepts of medicine that we all ascribe to. In this regard, we support the general approach taken by Medicare in its proposed rule limiting risk withhold and other types of incentives in HMOs with Medicare contracts. We believe that any health care reform legislation must regulate this practice. We believe there are ways to curb inappropriate utilization short of financial rewards for not referring and we would be pleased to discuss them further with this Committee or with the Congress.

Financing of Health Care Reform

We think it is important that fee-for-service medicine be preserved as a choice. While the Clinton proposal states that fee-for-service delivery systems and freedom of choice are important, we question whether, given the overall structure of the package including premium regulation, budget targets, and strict regulation of health care plans, fee-for-service medicine will be able to survive.

Thus, we are opposed to the global budgeting through regulation of premiums and the restrictions on the types of policies that plans can offer. While we recognize the need to control escalating health care costs, we believe the harm that would come from this approach would outweigh any benefits.

We believe a better approach is to use market controls to keep the costs of premiums down. Under a managed care system, if plans want to effectively compete, they will have to offer low premiums and this will result in limits on payments to providers. We believe that there should be direct negotiation between providers and plans which would result in cost effective therapy.

We also think that costs can be significantly reduced through the development and implementation of practice parameters and clinical guidelines so that only necessary and effective treatments are paid for and wasteful and inefficient medicine is reduced.

We are also opposed to the aspect of the fee-for-service option that requires providers to negotiate with the alliance for an alliance-wide fee schedule. We question whether negotiating with the alliance will be true negotiation since providers will likely not have any option but to take the fee schedule the alliance adopts. We also believe plans should have more flexibility to offer a variety of different cost-sharing options rather than being limited to only three, as the President's plan would do. We think that fewer restrictions in this area would allow for more innovation on the part of both insurance plans and providers in coming up with cost saving mechanisms without sacrificing quality. Therefore, we believe providers should be allowed to negotiate directly with the plans.

We also believe the limits on balance billing are unwarranted. We would support a means-tested right to balance bill and, at least speaking for our own specialty, do not believe this would be abused.

Physician Supply

With respect to the Clinton proposal on the physician workforce, we view with alarm the presumption that American medicine will be better off if we only increase the number of primary care physicians and decrease the number of specialists. While we support efforts to increase the number and distribution of primary care physicians, especially in rural and inner city areas, we believe that any reductions in the number of specialists should be undertaken with great caution and only after careful study. We are not opposed to a national approach to workforce planning, including limits on the number of residency slots and allocation by specialty. However, we believe the specialties must have substantial input into and control over this process. We are also concerned that the projections as to the number of physicians needed in a given specialty will be based on utilization of specialists in managed care delivery systems and that this may result in inappropriately low allocations of specialty residency slots.

The study by the Graduate Medical Education National Advisory Committee (GMENAC) indicated that there was not and would not be an oversupply of specialists in many areas including allergy and immunology in the foreseeable future. We believe reducing the number of allergy training programs when we are undergoing an increase in the incidence, morbidity and mortality of asthma would be detrimental to the needs of the American people.

Tort Reform

We are very pleased that the President recognizes the need for tort reform and we are very supportive of his proposals. We fully agree with the need for limits on attorneys' fees, the collateral source offset when computing compensatory damages, allowing for periodic payments of damage awards, the use of practice guidelines as a defense against malpractice, and the affidavit of a medical specialist as a prerequisite to filing a lawsuit.

However, we would like to see reform in this area go further. Specifically, we support a limit of \$250,000 on non-economic damages. In addition, we oppose the general use of alternative dispute mechanisms although we would not oppose demonstration projects to determine whether these systems are actually useful.

We specifically oppose the idea of enterprise liability. We believe it will create adversary relationships between the physician and the hospital or insurer and that it will lead to controls on the independent medical judgment of the physician. Physicians should be required to provide care within established guidelines and to justify care that is outside the guidelines. This is, in our view, the best way to protect the patient and the enterprise without limiting physician freedom and judgment.

Antitrust Reform

We were very happy to see that the President's plan includes reform in the antitrust areas. Reform of the antitrust laws and enforcement policies are genuinely needed if physicians are to negotiate on a level playing field with health plans and alliances. We believe reform in this area would be pro-competitive and is essential if physicians are to effectively compete. This is particularly true in our own specialty which is relatively small, and in which mergers frequently result in market power and thus run the risk of antitrust enforcement.

In closing, we want to emphasize that we are very supportive of efforts by the President, the Congress, and this subcommittee to enact meaningful health reform legislation. We believe it is critical that physicians play an active role in this process which will so greatly affect their profession. Thank you for the opportunity to present our views. I would be happy to answer any questions.

Mr. McDERMOTT. Dr. Burton.

STATEMENT OF JOHN BURTON, M.D., BOARD MEMBER, AMERICAN GERIATRICS SOCIETY, AND CLINICAL DIRECTOR, DIVISION OF GERIATRIC MEDICINE, JOHNS HOPKINS UNIVERSITY MEDICAL SCHOOL

Dr. BURTON. Mr. McDermott, members of the committee, thank you very much for allowing us to testify.

My name is John Burton. I am a geriatrician. I spend my life caring for the elderly patient, and I am a member of the board of the American Geriatrics Society. We are delighted to be able to testify again and appreciate the opportunity that we had earlier in the spring.

I would like to address 4 points, all of which are detailed in my handout. The 4 points are long-term care, prescription drugs, geriatrics as a primary care discipline, and the fact that the elderly need to be treated with equity.

The first point, long-term care. In caring for the frail, elderly individual, you need a full continuum of care services: Acute care, nursing home care, day care, house calls, and office care. Those need to be orchestrated and well organized into a continuum. Right now, the system is totally disconnected, without any logic to the system. People that suffer in that system are the frail elderly, who need comprehensive coordinated care.

This is not in the President's proposal, but there is an idea that there should be an experiment or a study to try to analyze this. We would be most delighted to participate in such a program.

The second point is prescription drugs. On many, many occasions I have had to hospitalize an elderly person because of the cost of prescription drugs. We now can do a great deal in controlling chronic diseases with the enormous advances in pharmacotherapy. But the cost is high, and, quite frankly, many, many elderly can't afford those, and we end up with a catastrophe. So we fully support the President's proposal for prescription drugs for the elderly.

Third point, geriatrics is indeed a primary care discipline, very much like pediatric care. It is really, in many ways, the best of primary care because caring for a frail older person with multiple problems requires the best of coordination and cooperation. That is what geriatricians do.

Finally, the elderly cannot be treated with a disequal system. We must be sure that we don't go back to the pre-1965 days. The elderly must have a system that is as equitable as those who are younger.

Thank you very much for the opportunity to speak before you.

Mr. McDERMOTT. Thank you very much.

[The prepared statement follows:]

Written Statement by
Dr. John Burton
Clinical Director, Division of Geriatric Medicine
Johns Hopkins University Medical School
and
American Geriatrics Society Board Member

October 26, 1993

Good morning Chairman Stark and distinguished members of the Subcommittee. I am Dr. John Burton. I am Clinical Director of the Division of Geriatric Medicine at Johns Hopkins University Medical School and am also a board member of the Society. As you heard from my colleague, Dr. Linda Fried, in April when she testified about our interest in including comprehensive geriatric assessment in the benefits package, the American Geriatrics Society is an organization of more than 6,000 physicians and allied health professionals with a special interest in the care of the elderly patient. We are honored to appear before the Committee and appreciate your interest in our views.

Today, I would like to raise six additional issues of importance to the American Geriatrics Society in the context of health care reform: long term care, prescription drug benefit, geriatrics as a primary care specialty, and the impact of health care reform on the Medicare program. Let me address the points in order:

1. Long Term Care

Recommendation: Long term care should be an integral part of our health care system.

We applaud the President for focusing on long term care as part of health care reform. Many of the steps taken in the President's anticipated legislation will address everyday concerns of the frail elderly and the disabled. However, the American Geriatrics Society believes that long term care should be an integral part of our health care system. As a person's health and function change, she or he needs the freedom to move throughout the continuum of long term and acute care settings. Artificially separating long term and acute care, as we currently do and will continue to do under the President's plan, creates a system that provides health care based on fiscal incentives instead of need, appropriateness, and efficiency.

As a person's health and function change, s/he needs the freedom to move throughout the continuum of long term and acute care settings. High quality care for these functionally dependent individuals requires that a primary care physician, such as a geriatrician, follow the patient throughout her/his lifetime. Continuous care should be provided by the primary care physician without regard to the setting in which the care is required. Continuity of care is important not just to deliver the highest quality care, but also to provide more efficient care.

If long term care is isolated from the rest of the health care system, use of long term care services will be governed by a different set of incentives. Acute care has incentives to ignore long term outcomes and to set up patterns of care that ensure that enduring care is "unusual." If long term care becomes an open-ended, welfare-entitled system, acute care providers will have incentives to "dump" patients into it.

Care for frail patients will be fragmented, leading to potentially inappropriate or incomplete care. Patients faced with different eligibility

for long term care services than for hospital or outpatient services, will continue to receive fiscally-biased care rather than care based on need and appropriateness.

Studies demonstrate that providing long term care services as an integral element of the care plan saves money and provides better care for patients. Attached are articles that illustrate this point.

One study by Rubenstein, et al. shows the cost-effective and quality-enhancing practice of assessing a frail patients' therapy and rehabilitation needs after a severe fall. (2) Using this assessment, patients required less hospitalization and were more mobile and independent after the fall. This success will not occur in the health care reform plan because short-term, post-acute rehabilitation therapy will not assure these results.

A second study by Rubenstein, et al. confirms that when simple interventions identified through a geriatric assessment, such as respite care and therapeutic rehabilitation, are provided "patients had a significantly longer survival and less use of acute-care and long-term institutional services...than similar patients receiving the usual hospital inpatient and outpatient services." (2) Further, these patients were "more likely to have an improvement in functional status and morale than those receiving the usual care.

To resolve these problems, the Society recommends that allied health plans (AHPs) provide the full range of services needed to meet patients needs, including home and institutional long term care. Second, that the AHP establish a primary care provider responsible for following seriously ill and disabled patients through multiple settings of care. Third, that health alliances establish outcomes measures to assure the quality of the care provided to these patients in all settings.

2. Prescription Drugs

Recommendation: Support the President's proposal.

The Society strongly supports President Clinton's inclusion of a prescription drug benefit for all Americans, including senior citizens, with a modest copayment. Although proper use of prescription drugs may prevent hospitalizations, surgeries and long term care placement, the high out-of-pocket expense of many drugs inhibits appropriate use.

Covering prescription drugs will reduce the current system bias that rewards overutilization of reimbursed procedures instead of management of care, which includes the use of prescription drugs. This will save money for the health care system, and assure appropriate, quality care.

For example, prescription drugs have reduced the costs and improved the outcomes of disabling illnesses such as stroke, myocardial infarction and ulcer surgery. Faced with inadequate financial resources, seniors may forego buying prescription drugs which are an integral part of care management. Poorly managed chronic disease may result in increased costs of care due to preventable complications, hospitalizations and surgeries.

Up to 90% of the elderly take at least one medication. Many take two or more and a third of all senior citizens pay more than \$300 a year for the drugs they need. This significant burden often inhibits their ability to comply with a recommended medical treatment regimen.

3. Access for the chronically ill and functionally disabled.

Recommendation: Encourage systems of care that do not discriminate against the chronically ill and functionally disabled.

A new system of health care payments to providers (either per capita or per service) must reflect the complexity of illness, particularly for the chronically ill and functionally disabled. Persons with chronic illness or functional disabilities often require frequent services, prolonged visits, long term care, and expensive medication regimens. Unless the complexity of illness is recognized, managed care plans and insurers will continue to systematically exclude chronically ill and functionally disabled people, such as senior citizens suffering from dementia, incontinence and stroke.

Persons with multiple chronic illnesses or severe disability may receive inadequate, fragmented, and inappropriate care in many managed care environments that do not recognize their needs. Avoiding patients with chronic illness and functional disability, such as heart disease, hypertension or diabetes is seen by many insurance companies as easier than developing cost effective care for these patients.

Systems of care that do not discriminate against people with chronic illness or functional disabilities or the providers best trained to meet their needs are more capable of meeting those needs in a cost-effective manner than our current health care system. Examples of these successes are the Fallon Community Health Plan in Worcester, MA and the On Lok demonstration in San Francisco.

4. Geriatrics as Primary Care

Recommendation: Include geriatrics in the primary care definition.

Geriatrics is a primary care specialty. Training geriatricians should be explicitly supported in policies to promote primary medical care.

By the year 2030, there will be proportionately more elderly than young people. The age 65+ population will have more than doubled in size. Geriatricians are uniquely trained to address the needs of this population. The Administration has appropriately recognized the importance of geriatrics in its health care reform proposal. However, the President's plan, as we have seen it, does not include geriatrics in its primary care definition. Instead, it treats geriatric training as a "special project."

Increasing the number of geriatric trainees has been recommended by the Council of Graduate Medical Education, the Institute of Medicine and the Department of Health and Human Services. Congress wisely recognized this important consensus in the recently passed budget reconciliation bill by noting geriatrics' primary care focus.

Like pediatricians caring for children, geriatricians provide continuous, comprehensive primary care that meets the needs of the elderly. Geriatricians provide comprehensiveness, coordination of services, and continuity of care. We also provide preventive services and manage acute and chronic illness. The geriatricians focuses on no particular condition or organ system. When we surveyed eight practices last year, the overwhelming proportion of billings -- eighty-five to ninety-seven percent - were for visits, not consultations or procedures.

In the past, the Health Resources and Services Administration (HRSA) programs for family medicine residency training have included geriatrics as a priority. This stimulated development of geriatric training in several programs.

More recently, however, these priorities have been eliminated and interest has significantly decreased. In 1989, 101 physicians entered geriatric medicine fellowship programs, while 772 entered cardiology training programs. Current incentives do not encourage medicine residents to become primary care physicians.

The Veterans Administration accounts for 40% of physicians trained in geriatric medicine over the last 10 years through geriatric research, education and clinical centers (GRECCs). This program is an ideal model for expanding support for geriatric training.

We recommend that the health care reform legislation include incentives to increase the primary care workforce and that geriatrics be included in the definition of primary care for the aforementioned reasons.

5. Increasing Primary Care Providers

Recommendation: Implement the Physician Payment Review Commission's recommendations.

The supply of primary care providers must be increased through adoption of the recommendations proposed by the Physician Payment Review Commission. Cuts in medical education payments designed to reduce the supply of specialists and increase the supply of generalists have been inappropriate and ineffective.

Currently, the United States has an oversupply of specialists which is exacerbated by a reimbursement system that favors procedures, not management of care. Cuts in medical education payments will not produce the desired increase in primary care physicians. Instead, programs will rely more heavily on reimbursement from specialists for revenue to replace lost funds unless there is a comprehensive solution.

The Physician Payment Review Commission has recommended, and we strongly support, a three-tiered approach to preparing our physician supply in the 21st Century that assures quality programs for all specialties and shifts medical education incentives from specialty focus to primary care focus:

- Congress sets the overall target for residency slots;
- A commission sets the number of residency slots per specialty; and
- Residency Review Committees, or some other independent, quality-oriented, currently existing entities that assure the quality of medical education programs, assign residency slots to the appropriate programs.

We believe this is an appropriate approach because, attempts to refine Medicare graduate medical education payments have had no effect on the training patterns at medical schools (i.e., geriatric training was exempt from the 1986 Medicare medical education payment cuts, but many hospitals and medical schools did not increase their support for geriatric training). Secondly, primary care specialty programs will continue to require direct support since program costs continue to exceed revenue generated by these fellows.

6. Medicare

Recommendation: Provide parallel benefits for senior citizens.

No matter what happens in health care reform, the Society believes that Medicare beneficiaries should be treated fairly. In our opinion, this means that any additional benefits in benefit, co-payment or deductible assistance, or out-of-pocket limits should be available to the senior citizens as well.

Conclusion

While this is clearly not an exhaustive list of issues important for you to consider in health care reform, we believe that these are the key issues for the patients we serve. I thank you again for this opportunity to testify and am happy to respond to any questions.

References

- (1) Rubenstein, Laurence Z., MD, MPH, Alan S. Robbins, MD, Karen R. Josephson, MPH, Barbara L. Schulman, RN, GNP, and Dan Osterweil, MD. "The Value of Assessing Falls in an Elderly Population: A Randomized Clinical Trial". *Annals of Internal Medicine*, Vol. 113, No. 4 (15 August 1990), pp. 308-316.
- (2) Rubenstein, Laurence Z., MD, MPH, Karen R. Josephson, MPH, G. Darryl Wieland, PhD, MPH, Patricia A. English, MS, James A Sayer, Dr.PH, and Robert L. Kane, MD. "Effectiveness of a Geriatric Evaluation Unit". *The New England Journal of Medicine*, Vol. 311, No. 26 (27 December 1984), pp. 1664-1670.

Mr. McDERMOTT. Dr. Lloyd.

**STATEMENT OF ROBERT J. LLOYD, M.D., CHAIRMAN,
LEGISLATIVE AFFAIRS COMMITTEE, COUNCIL ON
RHEUMATOLOGICAL CARE, ON BEHALF OF THE AMERICAN
COLLEGE OF RHEUMATOLOGY**

Dr. LLOYD. Good morning. My name is Dr. Robert Lloyd. I am a practicing rheumatologist, and I am here representing the American College of Rheumatology. We are pleased to provide a statement to the health subcommittee on the President's health care reform proposals.

The American College of Rheumatology is the professional organization of rheumatologists. It includes practicing physicians and research scientists who are dedicated to preventing disability, healing and eventually curing the more than 100 types of arthritis and related disabling and sometimes fatal disorders of the joints, muscle and bones.

As the primary providers of ongoing, comprehensive care to people with arthritis and related diseases, we are strongly supportive of elements of the plan which increase access to care and portability of medical insurance as well as create incentives for primary care. We also wish to highlight our support for efforts to increase funding for medical research, to streamline the administrative burdens in health care and to reduce the physician hassle factors.

We are pleased that one of the fundamental goals of the administration's proposal is universal coverage. The college strongly supports the proposal's emphasis on acceptance of all eligible individuals, open enrollment periods and prohibitions on preexisting conditions and disease-specific exclusions.

The college also supports the new health work force proposals to train more physicians in primary care, including the provision that would provide funding directly to training programs approved for residency training positions. We hope this provision will lead to the development of nonhospital based training, particularly programs that provide a greater portion of training in the ambulatory setting.

One aspect of this work force proposal that we do not support is the statutory requirement that 50 percent of residency training positions must be reserved for general internal medicine, general pediatrics and family practice. We fear this requirement would work to inappropriately limit the number of physicians entering residency programs in some of the nonprocedural evaluation and management specialties, such as rheumatology. Physicians in these specialties serve both as primary caregivers and specialists—as specialists for certain segments of the population.

On the subject of Medicare, we strongly support basing practice expenses on resources. We do not support the proposal to redistribute office consultation relative value units to all office calls. Consultations do involve more resources than office visits and should appropriately have a higher work relative value unit.

We would also like to state our opposition to global budgets and caps on Medicare. Instead, spending targets that have some flexibility according to the effects of improvements in medical tech-

nology and change in America's demographics in the future should be utilized.

The college is pleased that Medicare will cover outpatient drugs under part B. We believe this provision will lower costs for our patients on medications for chronic, often disabling conditions such as arthritis.

Finally, the College believes the choice of a physician is an essential component of reform. We believe the individual must be allowed to choose a health plan based on cost and quality, and the health alliances should not limit options. We are concerned about subjecting access to a rheumatologist to gatekeeper requirements if a patient chooses to stay within a network health plan. We are also concerned about the restrictions of any willing provider to join an individual health plan.

We appreciated this opportunity to provide input on the administration's health care proposal. Thank you.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]



AMERICAN COLLEGE OF RHEUMATOLOGY

60 Executive Park South, Suite 150, Atlanta, Georgia 30329
Telephone 404-633-3777 • 404-633-0199 • FAX 404-633-1870

STATEMENT OF THE AMERICAN COLLEGE OF RHEUMATOLOGY TO THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH REGARDING THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL

OCTOBER 26, 1993

The American College of Rheumatology (ACR/The College) is pleased to provide a statement to the Health Subcommittee, of the Committee on Ways and Means on the President's health care reform proposals.

The American College of Rheumatology is the professional organization of rheumatologists. It includes practicing physicians and research scientists who are dedicated to preventing disability, healing and eventually curing more than 100 types of arthritis and related disabling and sometimes fatal disorders of the joints, muscles, and bones. As the primary providers of ongoing, comprehensive care to people with arthritis and related diseases, we are strongly supportive of elements of the plan which increase access to care and portability of medical insurance as well as create incentives for primary care. We also wish to highlight our support for basing practice expenses on resources and fostering non-hospital based residence training, particularly in the ambulatory setting:

- The American College of Rheumatology's longstanding primary concern with any health care reform proposal has been that it provide adequate access to appropriate care for people with arthritis. We are pleased that one of the fundamental goals of the administration's proposal is universal coverage. ACR strongly supports the proposals emphasis on acceptance of all eligible individuals, open enrollment periods, prohibitions on pre-existing conditions and disease-specific exclusions, and portability for urgent care delivered outside of a plan's service area.

ACR is pleased with the President's proposal's emphasis on the importance of primary care medicine. In many cases, rheumatologists provide primary care for their rheumatic disease patients. By the nature of the rheumatologic diseases that we treat, rheumatologists are in the position of developing long-term relationships on the primary care level with their patients. Rheumatology is geared towards the prevention of disability. The fact that the field of rheumatology has no procedures other than joint aspiration shows that rheumatology is truly evaluation and management oriented and different from other specialties.

- ACR supports the new health workforce proposal to train more MDs in primary care medicine, including the provision that will provide funding directly to training programs approved for residency training positions. We hope that this provision will encourage the development of non-hospital based training, particularly programs that provide a greater portion of their training in the ambulatory setting.

The ACR has believed, for quite some time, that teaching in the ambulatory care setting, particularly in the physician's private office, allows medical students and residents to experience the rewards of long-term relationships common in community practices. Outpatient teaching exposes residents to the mix of patients and range of problems that typify a community practice and provides an opportunity to acquire skills that span a continuum of care, from health promotion to managing chronic diseases. Unfortunately, costs associated with ambulatory training and insufficient funds to finance these additional costs have been major barriers to ambulatory care teaching. We therefore strongly support movement toward fostering an increase in training in the ambulatory care setting, particularly in the private office setting. Moreover, we believe that because rheumatologists practice a medical specialty that can provide both primary care and specialty care, their practices are ideal settings for ambulatory teaching.

One aspect of the health workforce residency training proposal that we do have reservations about is the statutory requirement that 50% of residency training positions must be reserved for general internal medicine, general pediatrics, and family practice. We fear that this requirement could work to inappropriately limit the number of MDs entering residency programs for some non-procedural evaluation and management specialties, such as rheumatologists, that serve as the

primary caregivers and specialists for certain segments of the population. We are concerned that a statutory requirement 50% of residency training positions for this limited definition of primary care will lead to access problems for patients afflicted with rheumatic disorders. We could support a statutory requirement that 50% of residency training positions be reserved for primary care if non-procedural evaluation and management specialists who provide primary and specialty care are included in the equation.

In general, we question whether workforce composition requirements should be statutorily set. Instead, we believe that workforce composition issues should be considered by the National Council on GME and regional councils, as described in the plan, and issued as a proposed rule with opportunity for public comment. Because that commission will represent medical educators and practicing physicians, this method of coordinating residency training slots should create a graduate medical education program which medical educators and practitioners consider appropriate to properly treat the citizens of this country.

With regard to other aspects of the health reform proposal, the ACR has the following views:

- ACR believes that choice of physician is an essential component of reform. Because of our concern about the provision of optimal, cost-effective health care to patients with arthritis and related rheumatic diseases, we support the requirement that each health alliance must offer a fee-for-service plan and a point of service plan. However, we urge the Administration to go further to guarantee individual choice by eliminating the option to waive the fee-for-service plan offering and lifting the range of price differentiation so that fee-for-service plans are not unfairly excluded from the health alliances. We believe that the individual must be allowed to choose a health plan based on cost and quality, and that health alliances should not limit individuals' options. Further we feel that patients with arthritis or other serious rheumatic diseases should have the right to access to a rheumatologist under a network health plan, rather than only if the patient selects a more costly fee-for-service option. We are therefore concerned about subjecting access to a rheumatologist to gatekeeper requirements if a patient chooses to stay within a network health plan. As we mentioned at the beginning of this letter, by the nature of most rheumatologic diseases, rheumatologists are in the position to develop long-term relationships with their patients. We are concerned that health plans' reliance on primary care generalists, such as family practitioners and general internists, will systematically limit the availability of adequate care for patients afflicted with rheumatologic diseases.

We are also concerned that the Administration's health care proposal will allow the restriction of "any willing provider" to an individual health plan. This restriction limits the ability of a health care provider to serve the patient population which, he or she was trained to serve. Clearly, the restriction of any willing provider limits a patients access to different health care options. We feel strongly that patient choice must be considered paramount to restrictions of an individual health plan.

- The ACR strongly supports the decision to include a provision mandating the implementation of a resource based practice expense RVU method for the Medicare Fee Schedule (MFS). ACR has been in the lead in supporting the basing of the practice expenses component of the MFS on resources. We believe that this is the most equitable way to reimburse physicians for their overhead costs.

One of the primary reasons for the implementation of the Resource Based Relative Value Scale (RBRVS) was to create a more level playing field by removing the financial incentives that encouraged physicians to enter highly technical and procedure oriented specialties. This was to be accomplished by establishing a system in which the physician is reimbursed based on the cost of resources used to deliver a particular procedure or service. However, a major component - 41 percent - of the RBRVS, practice expenses, is not resource-based but still based on historical charges. This results in an inequity where many surgical procedures are systematically overvalued, while primary care and other evaluation and management services remain undervalued.

Rheumatologists experience significantly higher practice costs as a percentage of income than most physicians because they are primarily office based, see fewer patients per day while providing lengthier visits, and for the most part conduct very few invasive surgical procedures or diagnostic testing that would generate additional income to cover their overhead costs. It was reported that the practice expenses for rheumatologists accounted for 54 percent of their income, the highest percentage of any other medical specialty studied.

In Addition, inequitable payment schemes have led to frustration within the evaluation and management physician community. It has become increasingly difficult to recruit physicians in evaluation and management-oriented practices, such as rheumatologists, general internists, and family physicians, because of existing payment inequities. Providing for a resource based

practice expense methodology will provide a necessary financial incentive for medical students and new physicians to look past procedurally based specialties and investigate what practice in primary care and related evaluation and management specialties has to offer.

- ACR does not support the proposal to redistribute office consultation RVUs to all office visits. Office consultations do involve more resources than office visits, and should appropriately have a higher work RVU. The credibility of the RBRVS is based upon the belief that it objectively measures the resource costs of physician services; this proposed change would undermine that credibility.
- ACR supports the coverage of outpatient prescription drugs under Medicare Part B. The costs of prescription drugs for many of our patients are staggering. We believe this provision will lower costs for our patients on medications for chronic, often disabling conditions such as arthritis.
- ACR supports the Administration's efforts in the health care reform proposal which will help streamline the administrative burdens in health care, and reduce the "hassles" which can take physicians away from their primary agenda, which is to provide quality health care.
- ACR supports the Administration's efforts to reform medical liability. We especially support the idea of developing a pilot program to test the effectiveness of using practice guidelines as acceptable medical practice similar to the new Maine Medical Assessment Program. Physicians demonstrating compliance with the guidelines would not be held liable. We do believe however, that the measures in the current proposal do not go far enough to solve this problem which drains a tremendous amount of resources out of the health care system. Specifically, we recommend that a cap be placed on noneconomic damages and a sliding scale limit on contingency fees be added. We also appreciate the Administration's efforts to create "safe harbors" for physicians to negotiate and form their own integrated arrangements. However we believe that additional improvements in anti-trust law are needed, as well. On these two policy areas, we believe that further input from the medical community, and particularly the American Medical Association, will be needed to make the liability protection and anti-trust provisions truly meaningful in the context of the reform package.
- In the area of financing the health reform plan, ACR has some very serious reservations. In particular, we would like to state our opposition to global budgets and caps on Medicare. These budgetary restrictions will further ratchet down medicare reimbursement level to an unacceptable level. OBRA-93 already cut \$56 billion from Medicare over the next five years; we do not believe the Medicare program can sustain another \$124 billion in cuts without damaging the accessibility of high quality medical care for Medicare beneficiaries. It is also our fear that global budgeting places the concept of economics above the concern for quality medical care. Instead, spending targets that have some flexibility according to the effects of improvements of medical technology and the change in America's demographics in the future should be utilized.
- Finally, ACR strongly supports the plan to increase funding for medical research. ACR supports the provision for increased funding in the area of prevention research, and in particular the expansion of prevention research in the area of bone and joint diseases. In the area of "Health Services Research," we support the effectiveness research and the quality and outcome research provisions. Moreover, based on the integral role of biomedical research as the necessary precursor to health care delivery, we believe that an aggressive medical research program must be included in legislation to reform the health care system. Specifically, we agree with the finding of the Senate Appropriations committee (Report 103-143) that "careful consideration [should be given] to the establishment of a medical research trust fund to augment Federal appropriations for the biomedical enterprise supported by the National Institutes of Health". The ACR therefore urges you to consider proposing new mechanisms for generating additional funding for biomedical research activities, for example a monthly set-aside from health care premiums.

We appreciate the opportunity to provide input into the Administration's health care reform proposal. We believe that our recommendations will help make the reform plan more fully responsible to the needs of all Americans.

Mr. McDERMOTT. Dr. Davidson.

**STATEMENT OF EUGENE T. DAVIDSON, M.D., PRESIDENT,
AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS**

Dr. DAVIDSON. Mr. Chairman, I am Eugene Taylor Davidson, president of the American Association of Clinical Endocrinologists. I practice endocrinology and internal medicine at Watson Clinic in Lakeland, Fla. I am pleased to provide your health subcommittee this statement.

The Association represents the majority of endocrinologists practicing medicine in the United States. Our concern is the provision of optimal, cost-effective health care to patients with endocrine disorders. Endocrine disease affects every segment of our population, including osteoporosis, adults and children with diabetes, Graves' and other thyroid diseases, blood fat cholesterol disorders, hypertension, tumors of endocrine organs, and growth of metabolic abnormalities.

I confine my remarks today to one topic, that is patient choice and access to an endocrinologist for patients with endocrine disorders. Clarification of the role of the endocrinologist is necessary to maximize proper health care reform.

Endocrinologists have specialized training. However, we are not a procedure-based specialty but rather disciplined medical providers trained to perform detailed evaluation and management of patients with diabetes and other glandular disorders.

In patients with diabetes, it has been conclusively proven in a study titled the Diabetes Control and Complication Trial, sponsored by the NIH, released in June 1993, that intensive regulation of blood sugar levels results in better outcomes and reduced instance of complications. The complexities of providing such intensive management makes it important that specially trained, experienced physicians direct this care. It is, therefore, critical to ensure the right of patients with diabetes to have access to an endocrinologist on the primary care level.

Similarly, the expertise of the endocrinologist is invaluable in the prevention and detection of osteoporosis, thyroid disease, and other endocrine metabolic diseases.

Patients must have the right to appropriate provider access under a network health plan but not just if the plan selects a more costly fee-for-service option. The American Association of Clinical Endocrinologists, therefore, opposes the requirement that access to an endocrinologist be subjected to gatekeeper restrictions if a patient with an endocrine disorder stays within the health plan. This problem is very evident in HMOs.

Endocrine care with early patient education ultimately results in the prevention and reduction of unnecessary pain and suffering from hospitalizations, amputations, complications, renal failure, blindness and neurological dysfunction.

In conclusion, let me reiterate the importance that managed care programs provide patients with diabetes and other serious endocrine disorders, the ability to choose an endocrinologist as their primary care physician.

I would like to thank you for this opportunity to present your health subcommittee with this information.

Chairman STARK [presiding]. Thank you.

[The prepared statement follows:]



American Association of Clinical Endocrinologists

2589 Park Street / Jacksonville, FL 32204-4554 / (904) 834-8230 / FAX (904) 384-8124

STATEMENT OF THE AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS (AACE)

TO THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

REGARDING THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL

OCTOBER 26, 1993

The American Association of Clinical Endocrinologists (AACE) is pleased to provide a statement to the Health Subcommittee, of the Committee on Ways and Means on the President's health care reform proposals.

AACE was founded in the Spring of 1991 to create a unified voice for clinical endocrinologists, nationwide, on issues affecting health care and the practice of endocrinology. We represent the majority of clinical endocrinologists practicing in the United States.

1. CHOICE: Maintaining Access to Care for Patients with Endocrine Disorders

AACE opposes the requirement that access to an endocrinologist will be subjected to gatekeeper requirements if a patient with an endocrine disorder stays within a network health plan. As endocrinologists, our concern is the provision of optimal, cost-effective health care to patients with endocrine disorders including diabetes, osteoporosis, and thyroid disease. These diseases affect every segment of our population including women (osteoporosis) and children (juvenile diabetes). In patients with diabetes, for example, it has been conclusively proven in a study titled the Diabetes Control and Complications Trial (DCCT) sponsored by the National Institutes of Health and released in June of 1993, that intensive regulation of blood sugar levels results in better outcomes, reduced incidence of complications, and is more cost effective in the long run. The complexities of providing such intensive management makes it difficult and impractical for physicians other than endocrinologists to direct. It is therefore critical to insure the right of patients with diabetes to have access to an endocrinologist on the primary care level. Similarly, the expertise of the endocrinologist is invaluable in the detection, prevention and treatment of osteoporosis, thyroid disease, and other endocrine disorders. Patients should have the right to this appropriate provider access under a network health plan, not just if the patient selects a more costly fee-for-service option.

In order to ensure the rights of patients afflicted with diabetes or other endocrine disorders to be treated by the medical providers most suited to care for their conditions, we urge that legislation regulating individual health plans require that such patients be allowed to choose endocrinologists as their primary care physician. The "gatekeeper" requirements embraced by most health plans, particularly HMOs, will severely diminish these patients' access to endocrinologists, who provides the most cost effective and medically efficient care for these patients. Lack of specialized care for patients with diabetes may be less expensive in the short run, but ultimately results in unnecessary pain and suffering for the patients and the waste of billions of dollars. It is of critical importance that managed care programs include provisions which allow a patient with diabetes or other serious endocrine disorders to choose endocrinologists as his/her primary care physician. Any other policy denies patients with diabetes the most cost effective and appropriate therapy.

For similar reasons, we do support the requirement that each health alliance must offer a fee-for-service plan and a point of service plan. However, we urge the Administration to go further to guarantee individual choice by: first, requiring that all health plans give patients a point of service option; second, eliminating the option to waive the fee-for-service plan offering; third, lifting the range of price differentiation so that fee-for-service plans are not unfairly excluded from the health alliances. The individual must be allowed to choose a health plan based on cost and quality. Health alliances should not limit the individual's options based on an arbitrary assumption that individuals can not make their own decisions.

We are also concerned that the Administration's health care proposal will allow the restriction of "any willing provider" to an individual health plan. This restriction limits the ability of a health care provider to serve the patient population which he or she was trained to serve. Clearly, the restriction of any willing provider limits a patient's access to different health care options. We feel

strongly that patient choice must be considered paramount to restrictions of an individual health plan.

2. **WORKFORCE:** Ensuring the Availability of Endocrinologists to Serve as Primary Caregivers for People with Endocrine Disorders

AACE appreciates the intent of the new health workforce proposal to train more MDs in primary care medicine. However, the requirement reserving 50% of residency training slots for training in family practice, general internal medicine, or pediatrics within five years of implementation does not adequately take into account the fact that certain medical specialties serve as primary caregivers for certain segments of the population, for example the role endocrinologists serve in the treatment of diabetes and other endocrine disorders. Capping the number of residents entering some specialties could limit patient access to specialists, such as endocrinologists, that appropriately serve as the primary caregiver for certain segments of the population. In general, we question whether workforce composition requirements should be statutorily set. Instead, we believe that workforce composition issues should be considered by a commission that represents medical educators and practicing physicians, and the commissions' recommendations issued as a proposed rule with opportunity for public comment. This method of coordinating residency training slots would create a graduate medical education program which medical educators and practitioners believe is necessary to properly treat the citizens of this country. In the alternative, we could support a statutory requirement that 50% of residency training positions be made available to primary care if the definition of internal medicine slots is altered to include key internal medicine sub-specialists, such as endocrinologists.

3. **CAREGIVERS:** Maintaining the Continuum of Care Provided to Patients, with Physicians as Leader of the Health Care Team

It is our concern that the proposal for the Department of Health and Human Services to develop a professional practice statute which will remove "inappropriate barriers" to the practice of Advance Practicing Nurses (APN) and Physician Assistants (PA) could interfere with the appropriate role of the endocrinologist as the physician supervisor of the diabetes health care team. We agree that APNs and PAs have the ability to provide a certain level of patient care, and that their services may help reduce the cost of health care delivery. However, we do not believe that these physician extenders should practice independently. They must practice both within the scope of their training and under the direction of a physician. With the movement to more integrated systems of health care, the value of primary and specialty care delivery in the context of a health care team under a physician's supervision becomes increasingly important. The concept of independent non-physician practitioners appears to be inconsistent with the goal of a physician-supervised team. Any reform effort must be developed in a way that will preserve the essential role of endocrinologists as the appropriate leader of the diabetes health care delivery team and to ensure the ability of all patients with diabetes to have direct access to an endocrinologist.

4. **BENEFITS:** Ensuring coverage of patient self-management education where provided under the direct supervision of the physician managing the patient's condition

As advocates for our patients, AACE members support universal access to a standard benefits package. We have long supported extending Medicare coverage to the outpatient setting for education of patients with diabetes regarding self-management of their disease where such services are provided under the direct supervision of the physician managing the patient's condition. The current situation of inadequate and inconsistent reimbursement for this service by third party payers has created an obstacle to ensuring that our patients can be well-trained, motivated participants in their own health care. Inadequate patient education has resulted in increased hospital admissions, excessive use of emergency room services, increased need for medications and a higher incidence of complications--*that can be prevented*. We therefore urge you to pursue adoption of a national policy to provide reimbursement for diabetes self-management education provided under the direct supervision of the physician managing the patient's condition in your health care reform effort.

AACE appreciates the intent the elements of the President's plan which provide incentive for physicians to enter primary care. We support the decision to include a provision that will require that the practice expense (overhead) component of physician payment be based on resources, rather than historical data. In addition to being more accurate, basing payments on resources expended will ensure more equitable treatment of office-based, resource-intensive physicians, including family practitioners, internists and primary care-oriented subspecialists such as endocrinologists.

AACE opposes the proposal to redistribute office consultation RVUs to all office visits. Office consultations do involve more resources than office visits, and should appropriately have a higher

work RVU. The proposed change would undermine the credibility of the RBRVS which is based upon the belief that it objectively measures the resource costs of physician services.

AACE supports the efforts included in the President's plan directed toward streamlining the administrative burdens in health care, and reducing "hassles" associated with dealing with third party payers. We are especially supportive of the proposal to make the Clinical Laboratory Improvement Act (CLIA) less burdensome and less costly to physicians. We appreciate the Administration's recognition of the need to put in place policies that will allow physicians to devote more of their time and energy to the practice of medicine.

AACE supports the steps in medical liability reform that have been included in the President's plan, but recommends that additional measures be included as well, including placing a cap on noneconomic damages and requiring a sliding scale limit on contingency fees. AACE supports the inclusion of "safe harbors" for physicians to negotiate and form their own integrated arrangements, but believes that additional improvements in anti-trust law are needed, as well. On these two policy areas, we believe that further input from the medical community, and particularly the American Medical Association, will be needed to make the liability protection and anti-trust provisions truly meaningful in the context of the reform package.

In the area of financing the health reform plan, we have some grave reservations. In particular, we would like to state our opposition to global budgets and caps on Medicare. These budgetary restrictions will further ratchet down medicare reimbursement level to an unacceptable level. OBRA-93 has already cut \$56 billion from Medicare over the next five years; we do not believe the Medicare program can sustain another \$124 billion in cuts without damaging the accessibility of high quality medical care for Medicare beneficiaries. It is also our fear that global budgeting places the concept of economics above the concern for quality medical care.

We appreciate the opportunity to provide input to the Health Subcommittee, of the Committee on Ways and Means on the President's health care reform proposals. We believe that our recommendations will help make the President's reform plan more fully responsive to the needs of all Americans, including those in the patient population served by endocrinologists.

Chairman STARK. Let me just run down again—you can pass or mention a plan. Without—I am not talking really about cost containment because, by definition, that is what these plans are supposed to do. But, in your experience, which plan or type of plan that you practiced with is the simplest in terms of hassle factor, paperwork, the least intrusive in your practice? Dr. Nelson.

Dr. NELSON. I think it varies quite a bit from what part of the country that you are in.

Chairman STARK. Your personal experience.

Dr. NELSON. Oh, I think the least obtrusive were the commercial carriers. The most pain in the neck for me was Medicare.

Chairman STARK. Like the Blues?

Dr. NELSON. Yes.

Chairman STARK. Not a preferred provider but a straight indemnity plan?

Dr. NELSON. Right.

Chairman STARK. OK. Dr. Carey.

Dr. CAREY. I agree. Private insurance companies probably are a little easier to deal with. It is my recollection that the PPRC did a study not too long ago that indicated that about 69 percent of physicians felt that the hassle factor involved—

Chairman STARK. I want your personal opinion, Doctor.

Dr. CAREY. That would be my personal opinion as well.

Chairman STARK. OK. Dr. Tinkelman.

Dr. TINKELMAN. I would agree from the standpoint of our private practice that that would be the easiest group to deal with.

Chairman STARK. The indemnity plan, not the preferred provider?

Dr. TINKELMAN. Yes, sir.

Chairman STARK. I make a difference there.

Dr. TINKELMAN. Yes, sir.

Chairman STARK. Dr. Burton.

Dr. BURTON. Yes, my own experience is essentially 100 percent with Medicare. And I must say that I also was around before 1965, and Medicare has accomplished a great deal. Universal access is something that we should achieve in this country without question, and I am very proud of that.

On the other hand, there are enormous difficulties with the current Medicare system. The hassle factor is really quite profound.

There are also enormous inequities in the system. For example, I am paid \$37 for doing a house call, which takes me on the average an hour, and \$150 for debriding a wound, which takes 5 minutes.

Chairman STARK. Doctor, I am aware an oncologist in Tennessee is making \$200,000 on markup on drugs under Medicare. So these dislocations work both ways.

Dr. BURTON. I completely agree with you, and I think there needs to be a solution to that problem. It is—in fact, it is part of the problem. I think it is driving people out of primary care disciplines. And unless it is dealt with—I believe it probably is easier to deal with if there is not a single-payer system because of the competitive nature. I have been disappointed in Medicare for the last many years for that very reason.

Chairman STARK. Dr. Lloyd.

Dr. LLOYD. I would say that the commercial insurance carriers certainly offer less hassles. Blue Shield is generally very easy to work with. Even their PPO is very unobtrusive.

Chairman STARK. Dr. Davidson.

Dr. DAVIDSON. Yes. I concur. I think change can be made more easily in the private insurance business than they can with the Federal Government. I favor that plan.

Chairman STARK. One more question for each of you. The President in his plan, would allow fee for service in each region, and would intend that for certain procedures, let's just say cataract surgery for the example of it, they would negotiate with someone to provide that cataract surgery at a contracted price. And then any participant in the fee for service, Medicare included, could go to that specific provider for their cataract surgery and not have any copays. They could still choose from among the fee-for-service options in the community, but if they went to this one person who signed up they would have no copays.

They propose to do that on a number of different procedures, where they could bundle all the services, either ambulatory surgery center and the radiologist and the anesthesiologist and the surgeon, the whole gang, and bid it out for a price. Would you be in favor of that practice or opposed to it, Dr. Nelson?

Dr. NELSON. We believe that all accountable health plans should offer a point of service opt-out, so that would be consistent with that in one sense. We favor a competitive pricing system where all—

Chairman STARK. That isn't point of service. That is just a plan for a procedure. Would you favor that or not? It is not new. They tried it on ophthalmology and suffered the wrath of that specialty.

Dr. NELSON [continuing]. As I was saying, in the fee-for-service system, we want all physicians to pick their conversion factor but reveal it, and patients would know what the payment was—

Chairman STARK. I know what you want. But what I am suggesting is what the President is offering you. Do you favor it or don't you?

Dr. NELSON [continuing]. And since the patients would know whether there was out-of-pocket exposure, in essence, we would favor what you are proposing, as long as there is a competitive system and people can choose, and as long as there is transparency so they know what they are getting in for.

So, yes, within that competitive system, the kind of scenario that you described would not be something we would oppose, as long as they had an opportunity to go outside of that with some reasonable out-of-pocket payment.

Chairman STARK. Twenty percent?

Dr. NELSON. That is reasonable.

Chairman STARK. On a \$10,000 procedure? It ain't reasonable for many of Dr. Burton's patients.

Dr. NELSON. Well, then they would have an opportunity to walk, talk with their feet.

Chairman STARK. Dr. Carey.

Dr. CAREY. There are two key concepts here. One is bargaining, and the other is—

Chairman STARK. No, no, just the plan. Can you tell me whether you think that you would approve of that plan or not?

Dr. CAREY. I would favor such a plan as long as the bargaining is legitimate bargaining and that there is a choice to turn down that option.

Chairman STARK. The only reason you go there is you don't pay the copay. Medicare would do the bargaining in each community and set up a deal and set the price.

Then people could go for a particular hospital and not incur copays. If you don't want to go there, you can still go to any of the fee-for-service options. That is—

Dr. CAREY. I would favor that if it were structured correctly, if the bargaining were really bargaining.

Chairman STARK. Right.

Dr. TINKELMAN. Yes, I would also favor that plan under that system because it allows those individuals who cannot afford any other option to still have the procedure performed, and it allows those who wish to have choice of their own particular physician to be able to know up front what those fees would be and to choose that system. I would be in favor of that, sir.

Chairman STARK. Dr. Burton.

Dr. BURTON. I would favor that also as an experiment in cost control. It must be good, and it must be done with human dignity and proper quality.

Chairman STARK. I guess it would be done on a straight price. Your feelings are my concern.

Dr. Lloyd.

Dr. LLOYD. I would agree that if, indeed, patients realize that they had the two different options and if price was important to them, they could elect to go that way, it would certainly be acceptable.

Chairman STARK. Dr. Davidson.

Dr. DAVIDSON. I certainly agree. I think, though, that the endocrinologist has problem of being in the plan, and that is one of our major complaints.

Chairman STARK. Well, thank you.

Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Gentlemen, in the last couple of weeks some modifications to the Clinton plan have come out, preliminary to the presentation of the draft tomorrow. They include, among other things, a reduction in the cigarette tax increase from \$1 to 75 cents. That is proposed, and of course, would reduce revenues to pay for the plan.

Friday it was indicated that they intend to increase subsidies to small businesses by raising the employee threshold from 50 to 75, which would increase cost of the plan to the tune of about \$2.5 billion.

Now, I gather that you all share Dr. Burton's concern about the Medicare cuts. Am I correct in that?

OK. And I gather, Dr. Burton, you feel that the hassle factor under Medicare would only be exacerbated if we were looking at another \$125 billion, in addition to the \$56 billion that we took out under OBRA 1993. Is that a correct interpretation?

Dr. BURTON. That is correct.

Mr. GRANDY. Well, factoring all of that together and realizing that we are still in this game to achieve some kind of cost control, you have all very articulately indicated how your specialties ought to be included in the plan. What is in the plan right now, the Clinton plan that you have looked at, that does not need to be there? Because, absent some kind of tax increase or a greater deletion from Medicare and Medicaid, the way this plan seems to be trending is we are going to have to downsize the benefit plan or find some new source of revenue to pay for it or phase it in over a longer period of time.

And I guess what I would ask you to comment on is, is there anything in the package right now that you think could be excised to contain costs but not compromise quality of care? Dr. Nelson.

Dr. NELSON. I think the benefit package, as it is currently structured, is reasonable, and I would hate to see it cut. I indicated that there are ways that we can get additional scorable revenue, such as a tax cap, in a managed competition system.

Mr. GRANDY. Well, I agree with that, but I am not sure that would necessarily pass muster in this committee or the House. Are you saying that the benefit package cannot be tampered with in your view.

Dr. NELSON. I don't think that is overly rich. And I think that if you were to cut it you would cut some necessary services.

Mr. GRANDY. Do you agree, Dr. Carey?

Dr. CAREY. I agree fully.

Mr. GRANDY. Dr. Tinkelman?

Dr. TINKELMAN. Yes, I do.

Mr. GRANDY. Dr. Burton.

Dr. BURTON. Yes. Furthermore, it needs to be expanded because long-term care is not included, other programs that are particularly important to the elderly.

Mr. GRANDY. Dr. Lloyd.

Dr. LLOYD. Well, there are some things in the plan like dental care for children, and eyeglasses, that haven't traditionally been covered by independent insurance plans, but I don't think eliminating those services would really make much of a difference in the price of the plan, so I think the package should probably stay as it is presented.

Mr. GRANDY. And, Dr. Davidson, you concur with the panel?

Dr. DAVIDSON. Pretty much so. I think if you are going to cut things it is a hard issue for legislative people to do.

Mr. GRANDY. Well, you have a tenacious grasp of the obvious there. I mean, obviously, nobody is looking forward to telling people that we are the congressional gatekeepers and we are passing on the responsibility, through managed care to primary care physicians, to block the path to your specialties.

But, quite honestly, let's be totally realistic about this. We are in the greatest experiment in behavior modification in recent memory, and that is the only way this is going to work.

Now, just before I conclude, because my time is expired, I think we have to start putting on the table the fact that I don't see how we can preserve and protect and expand Medicare, given these cost-containment requirements, without reforming it drastically. If

you think that is hard for you people to say, you ought to see it from our side.

But I must tell you that, as you all agree, that the plan cannot be touched, and you are all in agreement that Medicare is getting too big a whack. I haven't heard any of you say that we need a tax increase, although Dr. Nelson has sworn off on a tax cap, which I think is appropriate. We still don't have the revenue to pay for this. We still don't have the money to pay for what we presume is in the plan.

And I think we are still far afield unless we start talking meaningfully about how we take the health care program we have created for people over 65 and merge it with people under 65. The Chairman has one idea. Some of us have others. But I think that to say that somehow we can hold this group harmless or protect it from the winds and buffeting of reform is disingenuous at least.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

If I understood all your testimony, you, in answer to the chairman's question, said that you agree with the President's plan. Nobody here has any serious reservations about it, is that correct?

Dr. NELSON. That is not quite correct. I pointed out some problems.

Mr. MCDERMOTT. I want to pursue the issue, and I will give you a second.

The fact that the insurance companies will be running most of the HMOs causes you no concern, apparently. It is very interesting to listen to six physicians all say that. I am going to mark this down as a day to remember.

You can give me your concerns because I would like to hear if you have them. This is your last chance to say anything, before this committee, perhaps, on this subject. If you have a concern, you ought to tell us.

Dr. Nelson.

Dr. NELSON. My testimony outlines them. My oral testimony did as well. We are concerned about global budgets, price controls. But the basic principles within the President's plan, we are solidly behind. We endorse them. And we are concerned about the fragility of the movement toward reform and the amount of negativism that is endangering that.

Mr. MCDERMOTT. I don't understand your understanding of price controls in the President's plan. You know there are price controls in there? I mean, you understand that?

Dr. NELSON. Yes.

Mr. MCDERMOTT. How can you then say that you believe the President's plan will work? Because insurance companies are going to enforce those price controls.

Dr. NELSON. Well, we provide the alternatives, and we explain them—and, again, our testimony outlines the deliberative process to set targets and all of the stakeholders working to achieve those targets.

Mr. MCDERMOTT. So what you are really saying is you support universal access and cost control and some competitive way and maintenance of quality and free choice of physician, all the goals

all of us support, but the specifics of the President's plan, you are not sure you like?

Dr. NELSON. As I indicated in the testimony, eight of the specifics we support completely. And I identified the ones that we have problems with and provided alternative solutions.

Mr. McDERMOTT. The rest of you.

Dr. CAREY. It is very hard to say you agree or disagree with something that is as complicated as the President's plan.

Mr. McDERMOTT. We are going to have to vote on it.

Dr. CAREY. What I agree with is that universal access is a very desirable goal, so to that extent we agree with the plan. But again the devil is in the details. I think unless preventive health care programs and cancer prevention are included, plus a meaningful way of limiting malpractice issues, there are a myriad of other details that I think really need to be paid attention to before we could buy into it and say we agree with the President's health care plan.

Dr. TINKELMAN. Our statement also addresses areas that we have some concern about. And one of the areas that I believe also should be mentioned here is the reduction in manpower. I believe that this will greatly affect the ability of individuals to receive specialty care, and it will also greatly affect the education of primary care physicians because primary care physicians, as you expand the programs and expand the education which is suggested, need to be educated by those who have specialty training. And if there is a marked reduction, 50 percent over the next 5 years or 5 years of the plan, in specialists, then this education will not be adequate.

We also are very concerned about the possibility of stringent gatekeeper effect which would be implemented by negative incentives, which would, again, significantly decrease the ability for individuals to receive specialist care which we feel strongly and has been demonstrated will actually reduce costs in the long run.

Mr. McDERMOTT. Do you have any doubt that the trend you are alluding to will accelerate under the President's plan? That is, the institution of gatekeepers and making it more and more difficult for referrals to specialists because of the incentives given to the gatekeeper not to refer. Do you think that trend is going to stop or diminish?

Dr. TINKELMAN. If the plan is enacted the way it is at this point in time, I believe that that trend will increase. Because that will be the only way that managed care groups will be able to decrease costs—and if they have tight budgets. However, that this can be—should be discussed amongst physicians and specialists. And I believe that care needs to be addressed as a priority and cost needs to be addressed as a secondary issue. If cost is the only issue, then you might as well say, don't go to see physicians at all.

Mr. McDERMOTT. I guess my problem, I suppose, for practicing medicine was I never remember an insurance company ever calling me to consult with me on what they are were going to do. They did it. And then I had to live with it. The idea that the major insurance companies that would be running the HMOs nationally would somehow consult with physicians seems like a nice idea, but I—

Dr. TINKELMAN. I believe that this is being done in several areas. For instance, if you look at—and I would like to address our specialty.

If you look at the care of asthma, asthma is becoming an issue where it does cost \$6.2 billion a year, and the insurance companies join in alliance with physicians as well as the NIH to set up guidelines, guidelines for care, and also when to refer. And when this was done and put into place, if you will look in areas where this has been adopted by insurance companies, managed care plans, they have actually reduced significantly the number of hospitalizations, the number of emergency room visits and also the cost.

And this, sir, has been published in many medical journals, probably not economic journals, but is information which probably could be expanded to all specialists where specialist care actually reduces costs rather than increases costs.

Mr. McDERMOTT. My time is expired, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Let me welcome each of you here today and thank you for your testimony.

I want to especially welcome Dr. Tinkelman who is here from Atlanta, which I represent. Dr. Tinkelman, you and I have talked before, and I want to thank you for all of your valuable and good work, especially your research for kids with asthma, which is so desperately needed.

Doctor, could you elaborate on the question of gatekeepers and access to specialists and your thoughts for the health care plan? I know you have worked with various insurance carriers to develop guidelines on appropriate use of specialists.

Dr. TINKELMAN. Thank you, Mr. Lewis. I believe that this is a major issue that faces all of us as specialists with respect to health care for those people who have more than just mild illnesses that are perhaps most easily and best taken care of by the primary care physicians.

But, again, sticking with our specialty in particular, where the rising cost and the rising death rate and the rising number of hospitalization and emergency room visits has been demonstrated to be associated with asthma. Those insurance companies that have bought into the idea that providing better care would reduce their own in-pocket costs have especially embraced the concept that setting up appropriate times for referral is an issue that they need to give to all their primary care physicians.

So that in setting up these kinds of guidelines of what to do initially, how to take care of patients and when those patients exceed those levels of mild disease that they be referred, those individuals, therefore, go to see a specialist. And it has been shown that there is a reduction in further cost, further hospitalization, and, further, all costs associated with that.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott was just curious as to how many of you work in a staff model HMO. Any of you?

Dr. CAREY. Would you repeat the question?

Chairman STARK. How many of you work in a staff model HMO? Do any of you work in an IPA or capitated under an HMO?

[Dr. Tinkelman raised his hand.]

Chairman STARK. Thank you very much, gentlemen. I appreciate your contribution.

Our next panel consists of five physicians: Wilson Wilhite, Jr., the president of the American Society of Anesthesiologists; Allan Jensen, representing the American Academy of Ophthalmology; Alan Bennett, representing the American Urological Association; Norman Hertzner, president of the Society of Vascular Surgery; and Gary Silverman, who is the medical director of Northwest Surgicare.

Welcome to the committee, gentlemen. We will let you start off in the order which you are seated.

Dr. Wilhite, would you proceed?

STATEMENT OF WILSON C. WILHITE, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AND VICE CHAIRMAN, DEPARTMENT OF ANESTHESIOLOGY, UCLA SCHOOL OF MEDICINE

Dr. WILHITE. Thank you, sir.

At the outset, Mr. Chairman, in my capacity as ASA president, I wish to express our society's appreciation to you and to the members of this subcommittee and its staff for your support in requiring the recognition of actual time units under the Medicare RBRVS.

Turning to health system reform, we find that, in general, the AMAs stated concerns about the administration's proposal to a large extent reflect our own concerns. We, as anesthesiologists, are first concerned with the apparent bias of the administration's proposal toward managed care plans. We believe that the best measure of an anesthesiologist's contribution to care lies in the relative value guide method. We have serious doubt that either capitation or DRGs, hallmarks of most managed care plans, can even begin to approach the RVG method as the proper measure of anesthesia care.

Second, we oppose any Federal effort to diminish the States' traditional role in establishing professional practice criteria. States have proven themselves well qualified to deal with scope of practice issues for physicians and other providers alike.

Third, we are concerned by the administration's proposal to artificially limit the number of physicians to be trained other than in primary care. ASA believes it important that future training of physicians in various specialties should be based upon solid factual research and analysis and not simply upon some arbitrary allocation of residency slots.

Fourth, we regard the administration's proposal for professional liability reform as important as far as they go, but inadequate insofar as they fail to impose stringent limits on attorneys' fees and noneconomic damages, fail to require offsetting of collateral sources of plaintiff compensation and fail to authorize periodic payments of damage awards.

Fifth, we note that the administration apparently proposes to establish DRGs for outpatient radiology, surgery and diagnostic physician services. It will certainly come as no surprise to you that ASA vigorously opposes any such proposal.

Finally, we fully support the AMAs view that any reform of the health care system must include greater definition of the circumstances under which physicians may collectively negotiate, free of antitrust impediments. At the present time, the antitrust laws are being used by large, third-party payers, and by large institutions to whipsaw individual practitioners, including our members. The time has come to level the playing field.

Mr. Chairman, there is a clear need for health system reform, and there is merit in each one of the proposals, including your own Medicare for all plans. But, for us, the relative value, RVS, system used by Medicare clearly acknowledges the fact and the specifics of the anesthesiologist-patient relationship. Any reform finally adopted must equally acknowledge that relationship.

Thank you for the opportunity to offer these comments to you today, sir.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF WILSON C. WILHITE, M.D.
PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS & MEANS

OCTOBER 26, 1993

Mr. Chairman, I am Wilson C. Wilhite, M.D. I am a member of the Department of Anesthesiology at the UCLA School of Medicine, and am the current President of the American Society of Anesthesiologists. Our Society appreciates the opportunity to appear before the Subcommittee today, in order to offer our initial views on the various health system reform proposals now pending before the Congress.

At the outset, however, I wish publicly to express on behalf of all my colleagues in the specialty our appreciation to you, Mr. Chairman, and to the members of this Subcommittee and its staff, for your support in helping us to gain legislative definition of the appropriate method for reimbursement of anesthesiology services under the Medicare program. I refer specifically to the most recent action of the Congress in requiring the recognition of actual time units under the Medicare RBRVS, an action which would not have occurred without the leadership of this Subcommittee and the help of its staff. I will not pretend that our membership is comfortable with the ever-diminishing levels of reimbursement for anesthesiology services under Medicare, but we do believe that the proper *framework* for reimbursement is now in place -- due in major part to the work of this Subcommittee.

It is too early in the legislative process for ASA to state its support for, or opposition to, any one of the several plans now under consideration. ASA is formally on record as supporting the AMA's Health Access America proposal, essentially because of its emphasis on reforming the Medicaid program to assure a uniform set of health benefits for low-income individuals, on improving access to employer-provided insurance, on cost-reduction through professional liability reform, and on the need to maintain and improve quality of medical care. These are principles on which most physicians can easily agree.

ASA has also stated its support for universal coverage for all Americans as set forth in the Administration's plan, as well as its support for the elimination of pre-existing condition clauses and other insurance limitations impeding portability of benefits. ASA also favors the Administration's community rating requirement as a means of promoting equitable pricing of benefits.

ASA is of course familiar with the AMA's all-physician mailing of September 24 in which it comments in some detail on various aspects of the Administration's draft proposal for reform. In general, we find that the AMA's concerns as expressed in that document to a large extent reflect our own, but rather than simply repeat those concerns, I would like to focus on just a few points that are of particular interest to anesthesiologists.

We are first concerned with the apparent bias of the Administration proposal toward managed care plans. As a California physician, I am only too aware of the current popularity of managed care plans as a means for restraining increasing costs, but I am also aware that the GAO recently reported to you, Mr. Chairman, that no conclusive evidence exists that managed care plans in fact save money over other delivery systems.

ASA believes both patient and physician choice of plans must be retained for optimal patient care. In our view, both managed care and fee-for-service represent valuable delivery systems. We are thus pleased to note from this week's newspapers that the Administration plans to abandon its original proposal to limit the number of fee-for-service plans a health alliance may offer.

The vast majority of anesthesiologists practice on a fee-for-service basis, and we candidly believe that the very best measure of an anesthesiologist's contribution to care of a surgical or obstetrical patient lies in the relative value guide method, by which -- as under Medicare and almost all indemnity plans -- both complexity and time are taken into account. We have serious doubt that either capitation or DRGs, hallmarks of most managed care plans, can even begin to approach the RVG method as the proper measure of anesthesia care.

As noted, we fully support the concept that individuals should be given broad freedom of choice among various types of plans, and we are equally comfortable with the notion that individuals choosing high-option plans should bear the cost of that option beyond some defined point. We further believe that available choices should not artificially be skewed against fee-for-service plans, and support the concept that alliances should be strongly encouraged to use the RBRVS for determining physician reimbursement.

Second, we oppose any federal effort to diminish the states' traditional and unique role in establishing professional practice criteria. ASA is fully aware that various nursing groups have seized upon the federal health care reform initiatives as a means by which to avoid state regulation and to bootstrap themselves into practice opportunities for which their education and practical experience are often questionable. ASA believes that nonphysician providers are critical to the efficient delivery of care, but that such individuals are not substitutes for physicians. State legislatures and regulatory bodies have proven themselves well qualified to deal with scope of practice issues -- for physicians and other providers alike -- and in ASA's judgment, there is simply no basis for federal intervention in this area.

Third, we are of course most concerned by the Administration's proposal artificially to limit the number of physicians to be trained other than in primary care, as well as to manipulate the Medicare RBRVS to favor primary care specialists. In the case of anesthesiology, we are only now beginning develop, through the operation of a host of superb residency programs throughout the country, a sufficient number of fully-trained anesthesiologists to assure adequate distribution of their skills in underserved areas as well as major urban settings. We are also looking ahead: two months ago, ASA commissioned a major study of the nation's need for anesthesiologists in the next decade and beyond.

But just as the chairs of our academic programs are distressed by the change in Medicare reimbursement rules severely curtailing federal support for the teaching of anesthesiology residents, so all of us concerned by the Administration's proposed disincentives for medical school graduates to choose procedural specialties such as ours. ASA believes it important that future training of physicians in various specialties should be based upon solid factual research and analysis, and not, as appears the Administration's intent, simply upon some arbitrary allocation of residency slots.

Fourth, we regard the Administration's proposals for professional liability reform as important as far as they go, but inadequate insofar as they fail to impose stringent limits on attorneys' fees and noneconomic damages, require offsetting of collateral sources of plaintiff compensation, and authorize periodic payments of damage awards. We are encouraged by the Administration's proposal to test the effectiveness of using compliance with practice parameters as a shield against malpractice liability. ASA to date has probably achieved more in the definition of appropriate practice parameters than any other specialty society, and we have been most supportive of state legislative efforts to use those parameters as a measure of appropriate care.

Fifth, we note that the Administration apparently proposes to establish DRGs for outpatient radiology, surgery and diagnostic physician services. Mr. Chairman, it will come as no surprise to you that ASA will vigorously oppose any such proposal, just as we have opposed the so-called RAP-DRG proposals that have surfaced in the federal budget reconciliation process from time to time, most recently just this year. Some of our members have already been confronted with bundling demands by private third-party payers in various parts of the country, and in essence these demands relegate the anesthesiologist to a status subservient to the interests of the institution, and severely impede if not destroy the physician-patient relationship.

Finally, we fully support the AMA's view that any reform of the health care system must include greater definition of the circumstances under which physicians may collectively negotiate. In the judgment of our attorneys, the recent statement by the Justice Department and FTC setting forth enforcement guidelines

represented little more than a restatement of prior federal enforcement policy, and leaves physicians with most questions still unanswered.

We need greater definition of the concept of integration, and whether that can be accomplished only by the sharing of "substantial" risk or, as proposed by the AMA earlier this year, by other efficiencies that tend to offer pro-competitive advantages. At the present time, the antitrust laws are being used by large third-party payers and by large institutions to whip-saw individual practitioners including our members. The time has come for the Congress and the Administration to level the playing field.

ASA does not wish to be heard as opposing the Administration's proposal in its entirety; as noted above, it has many features we support. There is a clear need for health care reform, and there is merit in each one of the proposals now before the Congress. That includes your own "Medicare for All" proposal, Mr. Chairman. Although our members are frankly deeply concerned about the possibility of having to deal with a "super-HCFA" controlling the entire practice of medicine in this country, we of course recognize the fact that the RBRVS system used by Medicare clearly acknowledges the anesthesiologist-patient relationship, and defines reimbursement -- through use of base and time units -- for the anesthesia care rendered to each patient. Unfortunately, this cannot be said of many managed care plans, in which capitation and DRGs are increasingly becoming the order of the day.

Thank you for this opportunity to participate in the Subcommittee's hearings. Although we are aware that the Ways & Means Committee does not necessarily have jurisdiction over all the issues I have raised, we nonetheless recognize that the Committee's role in the upcoming legislative debate will be enormous, and we wish to be sure that the record before this Subcommittee reflects our principal current concerns and views.

Chairman STARK. Dr. Jensen.

**STATEMENT OF ALLAN D. JENSEN, M.D., SECRETARY FOR
FEDERAL AFFAIRS, AMERICAN ACADEMY OF OPHTHALMOLOGY**

Dr. JENSEN. Thank you, Mr. Chairman and members.

My name is Allan Jensen. I am an ophthalmologist in practice in Baltimore and secretary for Federal affairs of the American Academy of Ophthalmology. The academy represents 19,000 ophthalmologists, doctors of medicine who provide primary and comprehensive eye care.

The academy believes that all Americans should have access to quality health care. We commend the President's efforts to ensure universal access, develop a standard benefit package, reduce administrative burdens and reform the insurance market.

Although we have concerns. First, we are concerned about the impact of the plan on consumer access to their provider of choice. We recognize that choice is one of the President's principles, but, if implemented as outlined, his proposal will provide few options for consumers to shop for and pick their provider. We support inclusion of point-of-service and fee-for-service plans to achieve these goals.

Although we know the President is making modifications to allow alliances to offer wider variety of plans, we urge Congress to ensure sufficient choice to providers.

We commend efforts to develop a standard benefit package, but there are elements of the eye care portion we hope you will review. The proposal includes provisions which mandates coverage for routine eye exams every 2 years for persons over 18. It also includes a provision mandating coverage for treatment of vision defects.

While we appreciate attention given to these issues, we question their cost effectiveness. While we understand the desire for biennial eye exams, there is no evidence to support such exams for an asymptomatic patient.

Similarly, the defects in vision language may represent an expansion of coverage to treatments that have yet to be proven effective.

We recommend benefits based on risk factors and patient need as described in our own Core Eye Care Benefit Package which you have received. That package outlines cost-effective timelines for eye evaluations, including more frequent exams for high-risk groups such as African-Americans, who face a high risk of glaucoma, and diabetics, who face a risk of retinopathy.

We are also concerned about provisions which call for a Federal preemption of State scope-of-practice laws. We oppose any effort by the Federal Government to override a State's responsibility to ensure their citizens receive safe and appropriate care by properly trained providers. Provisions in the plan could result in individuals providing services for which they have not been properly trained.

With regard to the physician work force, we support spreading financial support for graduate education across all payers and programs which encourage service in rural and inner-city areas. We are troubled by a fast-track approach, given the weaknesses in our ability to accurately assess the Nation's future needs.

There do not appear to be sufficient data to decide about the number and type of physicians under a reformed system. The Academy has engaged the Rand Corp. to analyze the country's eye care manpower needs and will share the results of that study with you. A 5-year timeline to achieve a 50-50 ratio of specialty primary care physicians in training is too brief to preserve the quality of training programs and the patient care functions of academic centers.

We join those concerned that the reform effort might be financed by decreasing payments for services to the Nation's seniors. We hope Congress will look elsewhere for funding sources and maintain the integrity of Medicare.

We appreciate this opportunity to testify. We appreciate the opportunity to be involved positively in the reform process. Thank you very much.

[The prepared statement and attachments follow:]

**TESTIMONY OF ALLAN D. JENSEN, M.D.
AMERICAN ACADEMY OF OPHTHALMOLOGY**

Mr. Chairman and members of the subcommittee:

Good day. My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore and Secretary for Federal Affairs of the American Academy of Ophthalmology.

On behalf of the Academy's 19,000 ophthalmologists -- doctors of medicine who provide primary and comprehensive medical and surgical eye care, I am pleased to have this opportunity to appear before you today.

The American Academy of Ophthalmology strongly believes that all Americans should have access to quality health care including appropriate and affordable eye care. We believe that an appropriate level of eye care is necessary in order to promote general well-being, independent daily functioning, enhanced quality of life and increased economic productivity.

The Academy commends the President for making an effort to solve many of the significant problems that prevent health care services from being accessible to millions of Americans. In particular, we applaud his efforts to ensure universal access, develop a standard health benefit package, reduce administrative burdens, and reform the insurance market. We also welcome his interest in reforming antitrust restrictions.

However, like the rest of the medical community, ophthalmology has a number of concerns regarding the President's proposal. My testimony will focus on the most significant of these issues.

CONSUMER ACCESS TO PROVIDERS

The Academy is concerned about the impact of the President's proposal on consumer access to their provider of choice. While we recognize that "choice" is one of the President's principles for reform and that the Administration states that consumers will be able to choose their own doctors, we believe that, if implemented as outlined, the proposal will inhibit the ability of consumer to exercise "choice."

Patients have the most freedom of choice when their health plans allow providers to choose the provider they prefer. The Academy believes that the President should encourage point-of-service and fee-for-service plans in order to achieve these goals. These are the only plans that allow patients to see almost any provider they choose.

The benefits of point-of-service and fee-for-service plans may allow them to provide better quality care at a lower cost than traditional managed care plans. These plans allow patients direct access to the providers best able to treat their problems. They reduce treatment delays, ineffective visits to gatekeepers, and redundant care, in some cases.

A massive shift toward restrictive managed care programs will reduce patient choice. What will happen to families when their pediatrician participates in one managed care plan and their family physician participates in another restrictive managed care plan? Once in these managed care plans, their choices will be further restricted. Many families may be forced to choose between two bad options.

The President's plan actively discourages fee-for-service plans and would allow health alliances to eliminate such plans under a variety of scenarios. By forcing all private practice physicians to use the same fee schedule and by giving alliances the right to set those schedules, alliances would have the power to force all providers into managed care systems. Other conditions would allow the alliances to simply end fee-for-service in their area entirely.

The plans for point-of-service plans should be carefully reviewed to ensure that true choice is maintained. Prohibitive coinsurance, deductibles and coverage policies may negate true choice.

Allowing point-of-service and fee-for-service plans to compete with managed care programs would preserve patient choice, enhance competition and maintain high quality standards. Even expensive point-of-service and fee-for-service plans should be allowed to compete. Comparing high- and low-cost plans will allow policy-makers to determine whether low-cost plans are reducing the quality of their medical care.

We urge Congress to scrutinize the President's health system reform proposal to ensure that consumers will, in fact, have access to a provider of their choice.

STANDARD HEALTH BENEFIT PACKAGE

The Academy commends the President on his efforts to develop a standard benefit package. We believe that a national benefit package is one of the strongest elements of his proposal. There are, however, two elements of the eye care section of the benefit package that we hope Congress will review when the President's proposal is considered.

The President's proposal currently includes provisions mandating coverage for routine eye examinations once every two years for persons 18 years of age or more and coverage for the diagnosis and treatment of "defects in vision." The Academy appreciates the attention given to these important issues; yet, we question the cost-effectiveness of the two mandates. We understand the desire for biennial eye examinations; however, there is currently no available medical evidence to support such examinations for asymptomatic patients. Similarly, the "defect in vision" language is unduly vague and may represent an expansion of coverage to techniques and treatments that have yet to be proven medically necessary or cost-effective.

We recommend the inclusion of eye care benefits based on risk factors and patient need. The Academy's Core Eye Care Benefit Package outlines this approach.

The Core Eye Care Benefit Package provides a more cost-effective solution than is provided for in the President's package because it specifies coverage of only appropriate and effective care based on medical necessity. It does not promote routine biennial eye examinations in the absence of risk factors or symptoms of eye disease. Nor does it provide for "defects in vision" services that have not been proven medically necessary or cost-effective.

The Core Eye Care Benefit Package includes only services that have been evaluated scientifically in order to determine appropriate clinical indication for use and efficacy. For example, instead of providing for biennial eye examinations, the benefit package outlines an appropriate cost-effective timeline for eye examinations and evaluations, including more frequent periodic examinations for high risk groups such as African-Americans, who face a statistically higher risk of glaucoma, and diabetics, who face a higher risk of diabetic retinopathy. The package outlines less frequent examinations for those individuals with no-risk factors and healthy eyes.

The Academy believes that access to appropriate and timely care will result in better health for Americans and reduced overall national costs for disease treatment. We recommend the use of the Core Eye Care Benefit Package to ensure that the resources allocated for eye care under the President's plan are used effectively and cost-efficiently.

SCOPE OF PRACTICE

The Academy is concerned about the scope-of-practice provisions included in the President's proposal. The proposal defines covered services as those that a "health professional is legally authorized to perform in that State." At the same time, the proposal calls for Federal preemption of State scope-of-practice laws by indicating that "no State may, through licensure requirements or other restrictions, limit the practice of any class of health professional except as justified by the skill or training of such professional."

The Academy opposes any effort by the Federal government to override a State's responsibility to ensure that their citizens receive safe and appropriate care by properly trained providers. The individual States are in the best position to determine their particular health care needs and the professionals who can best meet that need. The vaguely worded provision of the President's plan could result in individuals providing health care services for which they have not been properly educated or trained.

The Academy strongly believes it is inappropriate for the Federal government to intervene in this area and that such involvement could threaten the delivery of quality health care. We urge Congress to protect the authority of States to make these critical scope-of-practice decisions.

PHYSICIAN WORKFORCE REGULATION

The Academy believes that all Americans share in the benefits reaped from high quality physician training programs. For this reason, we support the President's goal of spreading financial support for graduate medical education across all payers, not just the Federal government.

The Academy also agrees with the President regarding the need for programs that encourage and support physicians to serve in rural and inner city areas. These programs will serve to expand the availability of care in underserved areas, including those areas with minority and disadvantaged populations. The Academy commends the President's proposal in this area, most notably, his efforts to develop mechanisms to provide for adequate recruitment and support of underrepresented minority groups into the physician workforce.

We are, however, troubled by the President's fast-track approach to physician workforce reform given the weaknesses in our current ability to accurately assess the nation's future manpower needs. At this time, there does not appear to be sufficient information with which to base a decision about the exact number and type of physicians and health personnel required under a reformed system. We believe that comprehensive data should be the foundation upon which a long-term national health workforce policy is formed. Without it, all efforts will be premature.

The Academy has taken a leadership role in this issue. We have engaged the RAND Corporation to analyze the country's eye care manpower needs. Once completed this spring, a report of the findings will be delivered to members of Congress.

The Academy is also concerned about the five-year timeline set to achieve a 50:50 ratio of specialty to primary care physicians-in-training. This timetable is far too brief to preserve the quality of medical training programs and maintain the vital patient care functions of academic medical centers. A more cautious and deliberative approach to bringing the numbers of generalists and specialists into balance is necessary if this route of government intervention in physician supply is chosen.

The Academy's concerns about the effects of the President's proposal to quickly and tightly regulate the physician workforce are not unfounded. We should all recall the lessons learned from the government's past attempts to manipulate the nation's physician workforce, which contributed in part to the current and projected physician oversupply.

FINANCING

The Academy understands that new resources will be required in any effort to achieve universal access. However, the Academy believes the Administration is misguided in its efforts to finance the reform proposal through significant reductions in payments to Medicare providers.

Since as far back as the Omnibus Budget Reconciliation Act (OBRA) of 1986 and including OBRA 1987, 1989, 1990, the physicians who treat Medicare patients -- the nation's oldest and most ill -- have been asked to absorb reductions in their fees. As a result of these reductions, physicians who treat Medicare patients currently receive approximately 73% of what private payors reimburse for the same procedure according to Congress's own Physician Payment Review Commission. The Academy believes that an additional \$124 billion in Medicare reductions on top of the \$56 billion in reductions already mandated in the President's recent budget bill represents an extraordinarily heavy burden for ophthalmologists and other Medicare providers to bear.

Medicare patients make up a large portion of ophthalmologists' practices. Consequently, we will bear a large share of the burden of the Administration's next spending reductions. The Academy believes it is inappropriate for the Medicare program to be continually used as a "banker." We hope that as Congress considers the President's plan it will look elsewhere for funding resources and act to maintain the strength and integrity of Medicare -- the nation's most important health care program.

CONCLUSION

In closing, we commend the President for his leadership in health system reform. His efforts to ensure universal access, develop a basic benefit package, reduce administrative burdens and reform the insurance market have earned the support of the Academy and deserve the support of all Americans.

At the same time, the Academy has strong reservations about proposals which limit consumer access to a provider of their choice, mandate eye care services that are not medically necessary, override State scope-of-practice laws that safeguard the delivery of quality care, abruptly and strictly regulate the physician workforce and finance the reforms through reductions in the Medicare program. We believe these provisions will seriously and adversely affect consumer access and the availability of appropriate quality care for our patients.

We thank the members of the subcommittee for their attention to these issues and we appreciate this opportunity to appear before you.

American Academy of Ophthalmology
Core Eye Care Benefit Package

I. Definition of Core Eye Care Benefit Package

In order to ensure every American equal opportunity to good vision and eye health, basic eye care services should be made accessible for all, regardless of his/her ability to pay. The core eye care benefit package includes the following:

For healthy patients with no known eye disease:

- (1) preventive vision screenings and eye health screenings for children
- (2) refractive examinations for children and adults as needed;
- (3) preventive basic eye evaluations for adults
- (4) periodic comprehensive eye examinations for children and adults in general population; and
- (5) periodic comprehensive eye examinations for groups at high (statistically greater) risk for developing eye disease

For patients with eye disease:

- (1) periodic comprehensive medical eye examinations and other medical eye exams, including consultant and referral services
- (2) medical testing and diagnostic services, including laboratory and radiologic services
- (3) medical treatment of eye diseases on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
- (4) surgical evaluation and treatment on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
- (5) follow-up and monitoring

II. Fundamental Services

The fundamental services provided in the core benefit package are described as:

- 1) vision screening and eye health screening;
- 2) a refraction;
- 3) a basic eye evaluation;
- 4) a comprehensive eye examination;
- 5) medical and surgical services.

Patient education is an essential component of preventive services to provide patients with information on how to avoid eye injuries, reduce risk factors for disease, develop healthier behaviors and promote the benefits of early disease detection. For care to be optimal, patients need to be made aware of the importance and benefits of early detection and treatment of eye diseases and conditions, and take more responsibility for their own health.

There are two kinds of eye screenings. The **vision screening** consists of a testing of distance Snellen acuity with the patient utilizing the current spectacle correction (if any) for the purpose of detecting visual problems. It is not a truly diagnostic procedure and cannot detect all visual problems nor identify their causes. The screening is usually performed efficiently, as accurately as possible and at the lowest cost in order to serve the general population. It is most useful on a periodic basis for detecting visual problems in the pre-school and school-age population. An **eye health screening** consists of a vision screening with a general, brief history of any symptoms or previous eye diseases, and an abbreviated evaluation of the pupil, ocular alignment and motility, and the fundus. This does not require dilation of the pupil and could involve an ophthalmoscopic examination and intraocular pressure measurement. This is useful in a pediatric population where risks of developing eye disease are fairly low, but more common eye conditions can be screened through simple testing (strabismus and amblyopia). These screenings can be performed by a variety of providers.

A **basic eye evaluation** consists of a general history of the patient, complete history of eye symptoms or previous eye diseases and a brief evaluation of the gross anatomic and physiologic status of the eye. This would include a slit-lamp examination and ophthalmoscopic examination, but would not include dilation of the pupil. Testing of extraocular muscle motility, including a determination of visual acuity, measurement of intraocular pressure and a pupillary evaluation would be included. The basic eye evaluation should be performed by a qualified eye professional defined as one having competence to take and evaluate an appropriate systemic and eye history, to recognize risk factors, indications by family history and systemic conditions, signs and symptoms of eye disease and conditions and to perform and interpret the components of the evaluation.

A **comprehensive eye examination** is a more thorough medical exam, and consists of three major components: medical history, history of any eye conditions, and evaluation of anatomic function and physiologic status. A thorough history collects demographic data, past history, other systemic conditions, use of systemic and topical medications and other relevant information. During this process, information about the patient's general health status and any systemic symptoms are evaluated and interpreted. The evaluation of the anatomic status of the eye focuses on three major areas: lids, lashes, lacrimal apparatus, orbit and other pertinent features; anterior segment, including the conjunctiva, sclera, cornea, anterior chamber, iris, lens and posterior chamber; and posterior segment, including the retina, vitreous, uvea, vessels and optic nerve. Examination of the posterior segment is best performed and usually done through a dilated pupil and examination with a direct and indirect ophthalmoscope. The evaluation of physiologic function includes, but is not limited to the following: measurement of visual acuity with present correction, measurement of best corrected visual acuity obtained by refraction, testing of ocular alignment and extraocular muscle motility, evaluation of pupillary status and measurement of intraocular pressure. An ophthalmologist, by virtue of his or her M.D. or D.O. training, has the level of skills and knowledge to assess and interpret general medical history and examination, ocular and systemic signs and symptoms related to the patient's condition, and the competence to perform and evaluate this examination.

A **refraction** or examination specifically directed towards prescription of corrective lenses is defined as a fundamental service for the core benefits and should be covered when indicated by a change in the patient's visual function. A diagnostic refraction is an integral part of a comprehensive eye examination that is indicated at appropriate intervals throughout a patient's lifetime. A refractive exam consists of a quantitative measurement that yields the data necessary to determine the best visual acuity with corrective lenses and to prescribe these lenses. A refraction constitutes a significant component of eye care to the public. Because it is nearly universally applied to the general healthy population and its costs can be well-quantified, it is not normally considered as an insurable risk. For example, under the Medicare program, refractions have not been routinely covered, and the Academy supports this decision. However, as health care reform seeks to develop a more comprehensive health benefit package, and as refraction is an important component of total care and valued by the American public, it is included in this core eye care benefit package. A refraction is not recommended routinely in the absence of visual symptoms and is not necessarily required more often than outlined in the program of basic and comprehensive examinations. To assure good vision and eye health, any patient who perceives that his or her vision has decreased should be evaluated. These services would not necessarily include any other screening or basic examination.

Medical and surgical services include ordering and performing of appropriate supportive testing, prescription of pharmacologic treatment, performance of other medical procedures, evaluation for surgical treatment, performance of surgical procedures, including laser surgery, delivery of post-operative care, follow-up and monitoring of patients with eye diseases. An ophthalmologist, by virtue of their broad medical expertise, skill in diagnostic abilities and clinical decisionmaking in general patient management, and their specialized medical study of the visual system and training in treatment methods, should perform medical and surgical services for the diagnosis and treatment of eye diseases.

III. Proposed Elements of the Package

The following briefly describes the schedule for periodic eye examinations for children, adults and high-risk groups:

Children:

For all children, early comprehensive eye examinations are important to detect or evaluate inborn or congenital eye abnormalities and those associated with prematurity. These include fixation preference, ocular misalignment or ocular diseases leading to amblyopia, cataracts, glaucoma or tumor. There should be an eye health screening when the baby is in the nursery and at six months of age. There should be an eye health screening at approximately 3 years and 5 years of age. An initial comprehensive eye examination should be performed when a child is between three to six years of age. Between 7 to 18 years, children should have an eye health screening, and receive vision screenings at ages 8, 12, 14 and 18 years.

Adults:

For the general adult population without symptoms or other indications between the ages of 19 and 39 years, an initial comprehensive eye examination is indicated. In the absence of risk factors, symptoms or other indications, these healthy adults do not require routine annual evaluations. African Americans between the ages of 20 – 39 years old require a comprehensive eye examination every 3–5 years, because of a higher incidence and more aggressive course of glaucoma. All adults aged 40 to 64 years old should have a basic eye evaluation every 2–4 years, and adults over 65 years old should have a basic eye evaluation every 1–2 years. All adults should have a comprehensive eye examination once between the ages of 40 and 60 and once around the age of 65. A comprehensive eye examination should also be performed when indicated by risk factors, signs or symptoms.

High-Risk Groups:

For patients, both adult and children, at high (statistically greater) risk to develop eye diseases, such as having a systemic disease associated with eye problems, use of systemic medications with ocular complications, history of risks of eye injury due to vocation, or family history of eye disease, the frequency and intensity of examination should be increased to detect the onset of vision-threatening diseases as promptly as possible. Comprehensive eye examinations should be provided at appropriate intervals, with frequency depending on the risks encountered, the patient's condition and likelihood for detecting onset of disease as determined by clinical judgment.

Patients with Eye Symptoms and Diseases:

Patients who have signs or symptoms may first be identified through an initial screening or eye health screening. After a screening, children warrant a comprehensive eye examination if they have abnormalities upon exam; signs or symptoms of eye problems by history; multiple health problems, systemic diseases or use of medications associated with eye disease; relevant family history; or health and developmental problems that make screening difficult. (AAO Comprehensive Pediatric Eye Evaluation Preferred Practice Pattern, 1992)

The following eye symptoms or systemic diseases warrant referral for a prompt comprehensive eye examination: failure to achieve normal visual acuity in either eye unless cause of impairment has been medically confirmed by prior examination and visual acuity is stabilized, significant eye injury or eye pain, flashes of light, recent onset of floaters, halos, transient dimming or distortion of vision, obscured vision, loss of vision or pain in the eye, lids or orbits, double vision or excessive tearing, loss of any part of the visual field, abnormalities in the transparent media of the eye or in the fundus or optic nerve head; tumor or swelling of eyelids or orbit, protrusion of one or both eyes, inflammation of lids,

conjunctiva or globe, with or without discharge, strabismus, abnormal intra-ocular pressure, diabetes mellitus, eye abnormalities associated with thyroid disease, HIV-positive patients with ocular symptoms and all patients with AIDS. (AAO Guidelines for Appropriate Referral of Persons with Possible Eye Diseases or Injuries, 1992)

Individuals with acute eye symptoms should have a prompt comprehensive eye examination and appropriate follow-up visits. For patients with defined eye diseases or decreased visual function, appropriate medical and surgical services should be provided for diagnosis and treatment of their conditions. These services should meet the test of medical necessity and reasonable provision of care, based on current practice guidelines, and should be provided by qualified professionals. Patients with chronic eye diseases should be evaluated periodically, with the frequency of visits depending on the severity of the condition, the response to therapy and the potential for disease progression.

IV. Supplemental Eye Care Benefits

Supplemental services are services that patients may elect to purchase, or providers may elect to provide, but are not covered in the core benefit package. Of course, patients might elect to purchase additional preventive services, exams or treatments in addition to those stipulated in the core benefit package. Some supplemental services are very important for daily functioning and optimal visual function, but because of their relatively low costs to each individual and broad use in the population, do not appear to warrant universal coverage. Other services are considered more discretionary, e.g., cosmetic procedures, and are not included in an universal coverage plan. Ophthalmologists and other eye care professionals, such as optometrists, opticians, orthoptists, ocularists and others, can provide some of these services as part of a plan provided to their patients, or as separate optional services.

List of Supplemental Services

Vision Services:

- . Refractions if provided at more frequent intervals than indicated by a change in the patients visual function

Dispensing and Supplying of Eye Glasses:

- . Prescription of spectacles (except for aphakia and for first post-operative prosthesis)
- . Fitting of spectacles (except for aphakia and for first post-operative prosthesis)
- . Repair and refitting spectacles (except for aphakia)
- . Supplying of spectacles (except for aphakia)
- . Prescription, fitting and supply of protective eyewear for work and sports-related activities

Measurement and Fitting of Contact Lenses:

- . Prescription of optical and physical characteristics of and fitting of contact lens (excluding fitting of lens for treatment of disease)
- . Modification of contact lens, with medical supervision of adaptation
- . Supplying and replacement of contact lenses (excluding supply of lens for treatment of disease)
- . Patient education about lens use, lens wear and precautions

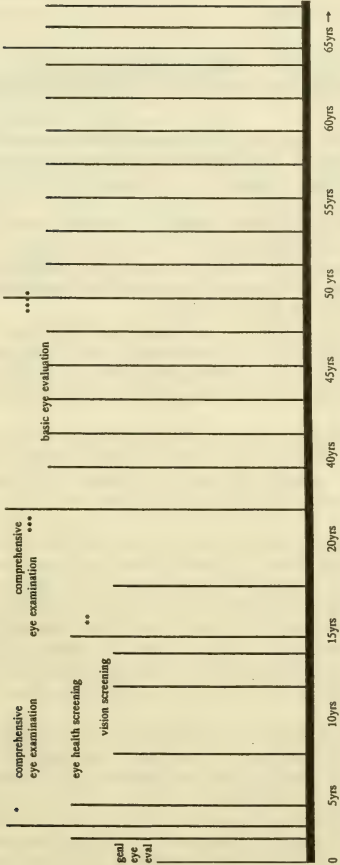
Cosmetic Ophthalmic Surgical Services

Surgical Procedures to Correct Refractive Error When Performed for Nonmedical Indications:

- . Refractive Keratotomy
- . Myopic Keratomileusis
- . Epikeratoplasty
- . Corneal Inlays
- . Photo-refractive Keratectomy
- . Intracorneal Ring
- . Hyperopic Keratomileusis

TIMELINE FOR EYE CARE EVALUATIONS AND EXAMS

* does not include evaluations for children and adults with eye symptoms



* indicates a comprehensive eye examination between the ages of 3 and 6 years

** indicates an eye evaluation between the ages of 7 and 18 years

*** indicates a comprehensive eye examination between the ages of 19 and 39 years old

**** indicates a comprehensive eye examination between the ages of 40 and 60 years old

(This timeline does not include the following visits:

Children and adults with high-risk factors are seen at appropriate intervals.

Children and adults with eye symptoms are seen promptly and as needed for appropriate treatment.

African Americans between the ages of 20 and 39 years old should have a comprehensive eye examination every 3 - 5 years)

Chairman STARK. Thank you.
Dr. Silverman.

STATEMENT OF GARY A. SILVERMAN, M.D., MEDICAL DIRECTOR, NORTHWEST SURGICARE, ARLINGTON HEIGHTS, ILL.

Dr. SILVERMAN. Thank you for the opportunity to testify before you. I am Gary Silverman, a practicing anesthesiologist and testifying as a concerned private citizen, a physician and health care consumer.

Since 1950, the administrative costs of health care have increased from under 5 percent to over 25 percent. Under President Clinton's plan, these costs will continue to spiral due to increasing and costly bureaucracies. The end results will be the destruction of the finest health care system in the world.

The plan also relies heavily on managed care for cost containment. According to a Office of Management and Budget study, if total population were enrolled in managed care, it would result in a one-time savings of \$90 billion with costs escalating just as rapidly thereafter.

In my freestanding surgery center, even though our costs are 50 percent less than those of hospitals, with higher patient and physician satisfaction, many plans will not contract with us, instead forcing patients into more costly, less efficient and less pleasant hospital settings.

Now is the time to return health care to the hands of the patient and the physician. As Abraham Lincoln once said, you cannot help mankind permanently by doing for them what they can and should do for themselves. Americans need to take responsibility for their own health care. While automobile insurance does not cover routine maintenance, health insurance should protect people from catastrophic illness. Insurance should be removed from the hands of corporations and the Federal Government and given back to the individual.

Through the creation of individual medical savings accounts, patients could purchase catastrophe insurance coverage with a large deductible. Routine costs would then be taken out of this account. Money not used could be allowed to accumulate for later use. Forbes Magazine recently instituted this type of health plan for their employees which resulted in over a 33 percent savings in health care costs. With payments coming from patients rather than insurance companies or the Federal Government, costs will tend to mediate due to natural market forces.

Prior to the inception of Medicare in 1965, health care costs rose at approximately 2 percent per year. By the ends of Medicare's first full year, costs were rising at 6.5 percent annually. By removing the Federal Government from health care, I believe the rate of health care inflation should be mediated.

It should be noted physicians fees remained constant at less than 20 percent since 1950. Finally, America is a country founded on individual freedoms.

Individuals must have the freedom to choose their own physician and determine with that physician what type of treatment is best for them and where that treatment is to be administered. Insur-

ance companies and Federal Government must not dictate where and by whom patients can get care. Physicians must also be able to choose the way they choose to practice.

They must be able to provide care based on medical training and experience not tethered by regulations set by managed care companies or other bureaucracies. If these freedoms are denied, health care in America will surely suffer.

More importantly, the very fabric of America society will suffer. Congress must act with caution and prudence to resolve the problems facing our health care system today. Any plans that are enacted will certainly be paid for by the generation of people to come.

Thank you for your consideration and for allowing to testify before this committee. I hope my comments will be of help in the continuing health care debate.

[The prepared statement follows:]



Northwest Surgicare

1140 West Central Road
 21401 Heights Illinois 60605
 708-249-1080

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October 21, 1993

**RE: TESTIMONY TO BE PRESENTED BEFORE THE SENATE SUBCOMMITTEE
 ON HEALTH CARE REFORM WAYS AND MEANS COMMITTEE**

Mr. Chairman,

Thank you for the opportunity of testifying before this Committee.

I am a practicing physician with over eleven years of experience. During these years in practice, I have seen increasing encroachment by third parties, insurance companies and the Federal Government, on the practice of medicine. I am gravely concerned about the future of health care in the United States and the future of my profession.

The Health Reform Plan proposed by President Clinton will surely result in a bureaucratic nightmare, the end result of which will be the destruction of the finest health care system in the world.

The Clinton plan, while purporting to decrease administrative costs, proposes 57 new bureaucracies and the expansion of 20 existing bureaucracies. The plan also proposes to allow for the private fee-for-service practice of medicine and to allow for patient choice of plan and of physician. In reality, patients will be forced into less costly managed care plans, where they will not only lose the right to choose their physician, but will have very little say in the type of treatment that is administered to them.

President Clinton's Health Care Plan relies heavily on the use of managed care for cost containment. It has been my experience that managed care does not hold down costs, it merely shifts them from patient care to administration. Most managed care plans engender bureaucratic costs that are twice that of other health insurance plans.

Mrs. Clinton recently appeared before this Committee and regaled you with stories of the uninsured. I would like to relate some stories to you of people who are insured under managed care plans and paying monthly premiums for insurance who have been denied access to necessary and needed care.

Recently, I had the opportunity to care for a lady with severe low back pain, severe enough to necessitate her being brought into our surgery center in a wheelchair. This patient contacted her managed care physician who instructed her to travel to an office 50 minutes from her home to be seen. After approximately a three-hour wait, she was seen by the managed care plan physician who proceeded to tell her that she was a young mother with three children, that her back pain was not related to any somatic illness, and that she should go home and forget about it. This patient's pain continued to worsen, and she sought the consultation of an orthopedic surgeon and paid for it out of her own pocket. The orthopedic surgeon found that she had two bulging discs and recommended that, in order to avoid surgery, she have an epidural steroid injection. The patient then contacted the plan physician who, of course, denied her request to have this procedure done. She then contacted me and, the next morning, we performed an epidural steroid injection on her. Her pain has greatly diminished, and she is now back to leading a productive life.

There have been great technological advances in the practice of medicine in the past decade. Many of these advances not only allow patients to receive treatment that was not otherwise available, but allows it to be done on an outpatient basis which results in cost savings and a more rapid return to work. One of these procedures is operative laparoscopy, whereby surgery that previously was performed with an open incision is now done through tiny puncture incisions with the aid of a laparoscope. Many managed care plans will not pay for this procedure. The end result is that these patients end up going to the hospital, having open surgery, staying in the hospital anywhere from two to four days, and then missing four to six weeks of work.

It is my impression that the further growth of managed care will limit the use of technologically advanced medical procedures and actually will cause us to go backwards rather than forwards.

I believe that the time has come to return health care where it belongs. Health care should be placed in the hands of the patient and the physician.

As Abraham Lincoln once said, "You cannot help men permanently by doing for them what they could and should do for themselves." Americans need to take responsibility for their own care. Just as automobile insurance does not cover the cost of routine maintenance, such as tire rotation or oil change; health care insurance was designed and should be used to cover the cost of catastrophic illness.

It is only when people begin to spend their own money that health care costs can be controlled. In my experience, patients that have little or no out-of-pocket expense tend to exhibit increased utilization of care. I believe that insurance must be the responsibility of every individual, not of corporations or the Federal Government.

Through the creation of individual medical savings accounts, every American could purchase catastrophic coverage with a large deductible. People under the poverty level could be subsidized by the Federal Government. By requiring all insurance companies to insure people, regardless of pre-existing conditions, insurance will then become readily available. This type of a medical savings plan has already been instituted by several corporations, Forbes Magazine being one. Last year, Forbes Magazine saved 33% on their health care costs.

Now is the time for Congress to act responsibly and with restraint. The mistakes of other countries who have provided health care entitlements to their populations must not be overlooked. One need only look at England, Canada, Italy, and Germany to see how health care costs are skyrocketing in these heavily entitled countries.

Finally, America is a country that was founded on the principles of personal freedom. I besiege you not to destroy these freedoms upon which this country was predicated. Individuals must have the right to choose their physician and to determine with that physician what type of treatment is best for them. Treatment should not be determined solely on the basis of cost.

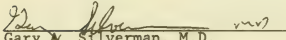
Physicians must also be able to choose the way in which they decide to practice, and they must be able to provide care based on their medical training and expertise, and not be tethered by rules and regulations set by insurance companies or other bureaucracies.

If these freedoms are denied, health care in America surely will suffer, but more importantly the very fabric of American society will suffer.

It has been an honor to be able to testify before this Committee, and I sincerely hope that my comments will be of help to you in the continuing health care debate.

I firmly believe that, if we act prudently and with caution, the problems facing our health care system can be resolved without throwing the baby out with the bath water.

Again, thank you for your consideration. The American people do not wish to have the health care system that they now enjoy destroyed.


Gary M. Silverman, M.D.
Medical Director
Northwest Surgicare
Arlington Heights, Illinois

Chairman STARK. Dr. Bennett.

STATEMENT OF ALAN H. BENNETT, M.D., CHAIRMAN, HEALTH POLICY COUNCIL, AMERICAN UROLOGICAL ASSOCIATION, INC.

Dr. BENNETT. Thank you, Mr. Chairman, members of the committee. I am Alan Bennett, a practicing urologist from Albany, N.Y., and chairman of the Health Policy Council of the American Urological Association. I represent 6,500 board certified urologists.

My advance statement touched on several issues about health care reform which concern the AUA. My brief remarks this morning will highlight 3 areas that urologists feel must be included in health care reform.

First, increased support for guideline development and utilization. Second, the inclusion of PSA tests for the early detection of prostate cancer. Third, the ability of patients to see urologists early in the course of their disease without being required to pass through a gatekeeper.

One criteria about health care reform is the need to maintain quality while pursuing effective cost containment. AUA is committed to the development of effective medical care guidelines and the conducting of outcomes research. Guidelines on prostatic hypoplasia, the most common disease treated by urologists, developed with the Agency for Health Care Policy and Research should be available shortly.

Those guidelines should represent a real opportunity to save money while improving the quality of care. The AUAs symptoms score developed in concert with these guidelines will determine when and what to do for our patients in a more efficient manner. Internally, AUA is funding 6 guideline projects on a variety of common urologic conditions.

Prostate cancer is the second leading cause of cancer deaths in men. It is similar to breast cancer in incidence and death rates. Mammography is a covered service, yet early detection of prostate cancer is not.

Although there are still controversies to be settled in the use of PSA and the treatment of prostate cancer, we can say with confidence based on recent data that we know how to find prostate cancer earlier than ever and that its early treatment leads to a better medical outcome. AUA recommends men over 50 be tested annually with a rectal exam and PSA; and with a family history of prostate cancer, screening should begin at age 40.

AUA believes the best trained individual to treat urologic disease is a board certified urologist.

Apparently our patients agree, as many come to us directly for treatment and not through a primary care referral. This allows early, cost-effective resolution of many urological conditions and avoids duplicative tests and treatment efforts.

Health care reform should not place additional barriers before our patients. This concludes my statement. I will be pleased to answer questions. Thank you.

[The prepared statement and attachment follow:]

**STATEMENT OF ALAN H. BENNETT, M.D.
AMERICAN UROLOGICAL ASSOCIATION**

Mr. Chairman and Members of the Subcommittee: My name is Dr. Alan Bennett. I am a urologist in private practice in Albany, NY, and Chairman of the American Urological Association's Health Policy Council. I am pleased to be representing the 6500 board certified urologists who provide medical and surgical services to men and women, specializing in conditions affecting the urinary tract and male reproductive system.

We appreciate the opportunity to testify today, and look forward to many formal and informal discussions between our medical specialty society and the Committee. We want to participate actively in the development of health care reform legislation, to advocate for quality care for our patients, and to seek improvements in the system of medical service delivery.

Before commenting on specific issues, let me express concern over the rigidity of the budget and structure in the President's health care reform proposal. We are opposed to a fixed national budget for health. We are not opposed to reasonable, responsible efforts to expend resources as economically as possible. Fixed budgets or caps will not promote, nor will they allow, the kind of cost effective system we need to develop.

The structure of alliances proposed by the President appears to be overly bureaucratic and unreasonably limits the role of physicians in the governance of these systems. More flexible and efficient management forms need to be found. Health care has more than enough bureaucracy today. We do not need to add to it under the guise of "reform".

MEDICARE

Urologists generally see a large number of Medicare patients because many urologic diseases are age related. Prostate cancer and urinary incontinence are two of the many conditions associated with the aging process that our members treat. HHS data show that 71.8 percent of urologists accept Medicare assignment, compared to the national average for all practitioners of 59.8 percent. Ninety-seven percent of urologists continue to accept new Medicare patients, according to a poll conducted for AUA by the Gallup Organization.

We are deeply concerned that the President wants to cut the Medicare program dramatically to finance health care reform. Medicare could not absorb a \$124 billion reduction in spending on top of the other reductions already enacted without negative consequences on patient care. If there are costs to implement health care reform, then they should be shared among us all.

We appreciate the reinstatement of fee equality for "new" physicians, and will continue to work with your Committee on clarifying other Medicare issues such as actual overhead costs. We are committed to improve the CPT coding system and resource based relative value scale to assure both appropriate coding for medical services and reasonable reimbursement. We hope that you will consider our voluntary efforts as proof that medical societies are willing to participate constructively in decision-making affecting our patients and practices.

In contrast to the President's health care reform proposal, Mr. Chairman, you have introduced H.R. 2610, the "Mediplan Health Care Act of 1993". While this approach would continue many elements which we strongly support, such as fee-for-service, and freedom of choice for patients and physicians, we would be reluctant to see Medicare extended to other sectors unless substantial improvements are made to the program. Among our concerns are the following:

- Health spending would be an even larger item in the federal budget, and even more subject to continuing deficit reduction pressures and competition for scarce federal dollars. Health care funds should be better insulated from the political process in order to assure service continuity and quality for patients.
- Over the last six years, urologists have felt the impact of yearly Medicare reductions targeted at surgical services, and the across-the-board cuts resulting from the implementation of the Medicare Fee Schedule. Program rules change constantly as a result and have become too complex and cumbersome.
- Our concern in using Medicare as the basis for a single-payor system also relates to the many inconsistencies in program operations, frustrations with the transition to the Resource Based Relative Value Scale and too much paperwork. For example, urologists who place a catheter in a patient during an office visit must file the claim for the catheter with a regional durable medical equipment carrier, rather than the physician's carrier, requiring extra time and paperwork.
- Urologists who perform laboratory tests in their office have been suffering the paperwork and costs of CLIA overregulation. We have worked with HCFA and CDC to reduce some of the burden, and hope that your Committee will support substantive improvements to CLIA and in the paperwork and reporting hassles endured by physicians.
- Medicare's benefits and coverage are not always current. The program is often slow or inconsistent in evaluating new services and incorporating them into the program. A vastly improved coverage process would be needed. For example, AUA is working with HCFA on four specific, technical payment/coverage issues. Progress is slow, in large part because there is no clear system in place to resolve these types of issues.

PHYSICIAN SUPPLY

AUA strongly believes in freedom of choice of provider for the patient. Patients should continue to have the opportunity to see a urologist as an initial point of contact without first going through a "gatekeeper". This saves time and money by allowing the patient to be evaluated, and treatment initiated, in the same visit, early in the onset of the condition when treatment choices may be most effective. We are concerned that the current emphasis on primary care might establish unnecessary barriers to urologic services and diminish access to specialized care.

We are also concerned about the proposed ratios for training specialists and generalists. Ten years ago urology teaching programs voluntarily trimmed numbers and improved residency quality. Currently, there are 8330 practicing urologists in the country, a ratio of 1:30,335, based on the general population of 252,688,000. Demand for the services of most urologists remains high. Our members are busy and working hard. When considering the rate of growth in the over-65 population, who experience a

greater incidence of urologic conditions, it is conceivable that the current ratio will be insufficient to meet patients' needs. For example, a urologist employed by Kaiser Permanente in southern California estimates their ratio of urologists to patients is 1:40,000, but theirs is generally a working-aged population, not retirees. Their ratio would have to change if greater numbers of retirees were participants. We urge the Committee to resist efforts to impose arbitrary limits on the number of urologists in training.

AUA supports the role of teaching hospitals in medical education, research and specialized care, and recommends maintaining federal and private financial commitments to these institutions.

SCREENING AND PREVENTIVE CARE

Prostate cancer is one of the leading causes of death among men. Early detection through digital rectal examinations and PSA testing allows physician and patient more treatment options to contain the cancer before it spreads to other organs, becoming impossibly painful in its last stages. Although the President has emphasized the importance of prevention and screening, the outline of his plan does not include early detection for prostate cancer. This omission should be corrected.

The AUA recommends that annual PSA testing and digital rectal examinations should be performed on asymptomatic men over age 50, and over age 40 with a family history, to provide early detection for prostate cancer. The American Cancer Society supports this recommendation.

GUIDELINES AND OUTCOMES

There are many unknowns in the treatment of prostate cancer, and AUA is actively involved in promoting basic research and developing practice guidelines to clarify our current knowledge. We are sponsoring a symposium later this year on many of the issues surrounding treatment of this common cancer. We are currently supporting guideline development panels in six areas of urologic care, including prostate cancer, utilizing Dr. David Eddy's methodology. The prostate cancer guidelines will be based on the best available peer-reviewed scientific literature, and include active participation by non-urologists, including an oncologic radiologist and an internist who is associated with Dr. John Wennberg's outcomes research project on prostate disease.

AUA initiated the guideline on treatment of benign prostatic hyperplasia, which was taken over by the Agency for Health Care Policy and Research. It should be released in January. Our initial achievement in this project was the publication of a BPH symptom index, among the first validated scales to evaluate the patient's condition before and after treatment. This index has been endorsed by the World Health Organization, and is considered by HCFA's Office of Medical Review to be a benchmark for their future quality assessment activities. The index helps urologists make better diagnostic and therapeutic choices for their BPH patients and has the potential to reduce significantly the costs of diagnosing and treating this common condition.

We are nearing completion of guidelines for the treatment of kidney stones, due early next year. This three year project involved a tremendous commitment of volunteer time. Guidelines on the treatment of bladder cancer, impotence, pediatric conditions, and female urinary incontinence are expected to be completed within the next year or so.

AUA urges the Committee to emphasize the continuing development and refinement of practice guidelines with the direct input of physician specialty societies as a key part of national health

reform. Federal support for basic research, outcomes research and guidelines development needs to be increased.

We believe that practice guidelines can promote quality, cost-effective care and ultimately save money by reducing unnecessary testing and procedures. They can help us all spend money for health care more wisely.

NEW TECHNOLOGY ASSESSMENT

AUA supports the development and dissemination of new techniques and technology where its efficacy has been demonstrated and reported in peer-reviewed literature. All too often, new technology moves into practice before it is sufficiently evaluated. Considerable expense could be avoided by reaching agreement on the evaluation of new technology. We have worked closely with the FDA to develop protocols for evaluating new technology, such as lasers used in treating BPH. As an organization, we have taken positions on new procedures and services that have made some of our members unhappy, but we are committed to assuring quality patient care, and scientifically validated treatment.

TORT REFORM

Cost-effective care can be promoted through tort reforms, similar to those adopted by California. The President's proposal does not go far enough toward correcting the weaknesses of our medical liability system. True tort reform will save society money and reduce unnecessary defensive medicine. Our Gallup poll results show that fifty percent of urologists perform additional tests because of litigation fears.

ANTI-TRUST REFORM

AUA recommends modification of the anti-trust laws and their interpretation to allow physician negotiation and the formation of physician and physician/hospital networks. This will promote efficiency through the sharing of equipment and facilities. It will also promote the participation of physicians in decision-making and negotiating quality care arrangements and equitable compensation.

Attached is a summary of our policy positions on national health care reform. We would be happy to answer questions on these and other issues, and to continue our dialogue in the weeks and months to come.



Policy Statement of the American Urological Association, Inc.

Policy Principles on Health Care Reform

(1) **Freedom of choice.** Patients should continue to have the opportunity to see a urologist as an initial point of contact without first going through a "gatekeeper"; and should have the opportunity to go outside of the plan at the patient's own expense.

(2) **Principles for Accountable Health Plans.** The AUA recommends that at a minimum, AHPs meet the following requirements:

- a) AHPs are not the exclusive mechanism for providing services.
- b) Any plan may be eligible to compete for designation as an AHP, whether capitated or fee-for-service.
- c) Physicians are permitted to join as many of the competing AHPs as they choose. Physicians are permitted to form AHPs and serve in key governance/management positions. Physicians are provided a structure for participating collectively in all levels of decision-making and issues concerning the AHP.
- d) The criteria for selecting participating physicians are public, and termination procedures reflect appropriate due process and appeal.
- e) Financial incentives related to the referral of individual patients are prohibited.
- f) If the plan conducts economic profiling of physicians, adjustments are made to reflect individual physician's case mix, age and patient severity of illness, and other features of the physician's practice.

(3) **PSA testing should be included as part of the basic benefit package.** Annual PSA testing and digital rectal examinations should be performed on asymptomatic men over age 50, and over age 40 with a family history, to provide early detection for prostate cancer.

(4) **Limits on new technology until validated by literature.** AUA supports the development and dissemination of new techniques and technology where its efficacy has been demonstrated and reported in peer reviewed literature.

(5) **Practice guidelines should be incorporated in health care reform.** Should health alliances and AHPs undertake the assessment of quality of care and/or utilization controls, the AUA recommends the use of practice guidelines, developed by or with the direct input of physician specialty societies.

(6) **Prioritization of health expenditures.** Should the level of benefits and/or access of uninsured be limited by budgetary concerns, the AUA recommends a process, similar to the Oregon Medicaid plan, whereby an independent body, including physicians and consumers, conducts a study of societal interests, and formulates a priority list of covered health care services.

(7) **Urologic care should be provided by competent physicians.** Should health alliances and/or AHPs establish selection criteria, then AUA recommends that urological care should be provided by physicians who have completed Residency Review Committee-approved residencies and have demonstrated continued competence in the field of urology.

(8) **Urologists Provide Ultrasonography.** AUA affirms that urologists are the physicians best trained to diagnose, manage and treat diseases of the genitourinary tract in patients of all ages. This includes possessing the skills in all aspects of diagnostic technology including ultrasonography, and other imaging techniques. There should be no economic disincentives for urologists to perform these services.

(9) **Funding for outcomes research and guidelines.** In order to meet the demands for treatment guidelines and outcomes assessments, there should be increased federal funding to support efforts conducted by and including physician specialty societies.

(10) **Support for teaching hospitals.** AUA supports the role of teaching hospitals in medical education, research and specialized care and recommends maintaining federal financial commitments to these institutions.

(11) **Anti-trust protection.** AUA recommends the enactment of appropriate anti-trust relief to allow physician negotiation and the formation of physician and physician/hospital networks.

(12) **Tort reform.** AUA recognizes the burdens of the current malpractice liability environment and supports tort reform similar to the plan in place in California.

AUA Health Policy Department contacts: Stephanie Mensh and Megan Cohen.

Chairman STARK. Dr. Hertzner.

STATEMENT OF NORMAN R. HERTZER, M.D., PRESIDENT, SOCIETY FOR VASCULAR SURGERY, AND CHAIRMAN, DEPARTMENT OF VASCULAR SURGERY, THE CLEVELAND CLINIC FOUNDATION

Dr. HERTZER. Mr. Chairman, members of the subcommittee, I am Dr. Norman Hertzner, chairman of the department of vascular surgery at the Cleveland Clinic Foundation and current president of the Society for Vascular Surgery.

Vascular surgeons deal with all circumstance related to problems involving the aorta, and the arteries in the neck that supply blood to the brain, abdominal organs and the kidneys, and the arms and legs.

Although we perform operations to repair aortic aneurysms, to prevent disabling strokes from atherosclerosis involving the carotid arteries, and to enhance circulation to the legs in order to avoid amputations, we also provide nonoperative evaluation and management services for countless Americans who have peripheral vascular disease that does not require surgical treatment.

About 70 percent of our patients are in the Medicare population.

One of the areas in which you probably are interested is whether we believe the new Medicare RBRVS could be adopted on a wider scale within the national health care reform. We now have spent over 2 years trying to refine the Medicare RBRVS so it will reflect clinical practice.

It has been a long and frustrating process to revise some of its original absurdities. We think vascular surgeons should have been directly involved with this development before the time of its implementation.

We are convinced that truly experienced surgeons could have constructed legitimate sets of relative values for vascular surgery in a fraction of the time and at a fraction of the cost that was expended on the RBRVS, whatever conversion factor may have been applied to it for reimbursement purposes.

Yes, we believe a RBRVS could be applied to broader health care reform but only after considerable revision. We hope you will agree with us that it makes common sense to invite the participation of practicing specialists from the outset in this kind of project. Whatever course you choose, it is absolutely critical for Congress to consider the quality of care and not just its cost.

In this respect, we believe—and what I am about to tell you is very important—there is substantial reason to believe the mortality and complication rates for common procedures are not known at most hospitals in the United States. Beyond the personal anguish they bring the patients who sustain them, substandard surgical results also are incredibly expensive. We believe that there should be some uniform process for hospitals to document their own results; and we have outlined some specific suggestions for such a plan in our formal statement.

In summary, the mortality rate and the incidence of certain complications for major operations should be prospectively audited on a continuous basis at every hospital. The specialty society representing each surgical discipline should select three national index

procedures and the specific complications to be reviewed in these audits.

Finally, we volunteer our own specialty of vascular surgery for a pilot study to test the feasibility of this approach. Our proposal has nothing to do with the level of professional premium reimbursement but would encourage thousands of hospitals to improve their quality of care and reduce the tremendous expense of unrecognized complication rates.

We would like to work with your subcommittee in the development of legislation to provide for this kind of quality assurance and accountability.

Mr. Chairman, thank you.

[The prepared statement follows:]

STATEMENT OF THE SOCIETY FOR VASCULAR SURGERY AND
THE NORTH AMERICAN CHAPTER OF THE INTERNATIONAL SOCIETY FOR
CARDIOVASCULAR SURGERY

PRESENTED BY
NORMAN R. HERTZER, M.D.

OCTOBER 26, 1993

Mr. Chairman and Members of the Subcommittee, I am Dr. Norman R. Hertzner, Chairman of the Department of Vascular Surgery at the Cleveland Clinic Foundation and the current President of the Society for Vascular Surgery. On this occasion I also represent the other national organization in our specialty field, The North American Chapter of the International Society for Cardiovascular Surgery.

Vascular surgeons are primarily responsible for the diagnosis and treatment of arterial and venous disease with the exception of that confined to the heart or to the intracranial blood vessels within the brain itself. In other words, we deal with virtually all other circulatory problems involving the aorta, the arteries in the neck which supply blood to the brain, the abdominal organs and the kidneys, and the arms and legs.

As just a few examples of our work, we perform operations to repair aortic aneurysms, to prevent disabling strokes from atherosclerosis involving the carotid arteries, and to enhance circulation to the legs in order to avoid amputations. According to a recent survey, however, only 40% of our new patients actually require surgical treatment. Therefore, we also provide nonoperative evaluation and management services for countless Americans with peripheral vascular disease, about 70% of whom are within the present Medicare population.

On behalf of vascular surgeons, I would like to take this opportunity to offer just a few comments on the topic of health care reform, and then to recommend a plan for outcome assessment which is long overdue and would greatly enhance the quality of surgical care at every hospital in the United States.

The Resource-Based Relative Value Scale

It is our understanding that one of the areas in which you are interested is whether we as vascular surgeons believe the new Medicare RBRVS should be adopted on a wider scale within national health care reform. You should first know that we have spent over two years trying to refine the Medicare RBRVS so that it will accurately and sensibly reflect clinical practice. The original relative value scale for approximately 220 CPT-coded services in vascular surgery which was submitted to the Health Care Financing Administration by Hsiao and his associates at Harvard contained so many absurdities that HCFA ultimately found it necessary to convene panels of carrier medical directors and practicing physicians in several attempts to improve it. Many of its inconsistencies were caused by the mistaken assumption that the intensity of pre- and postoperative management was unrelated to the severity of patient illness or to the magnitude of the surgical procedure that was necessary to treat that illness.

Because of this fundamental misconception, the Harvard RBRVS overvalued the work required for relatively minor surgical procedures and undervalued the work necessary for major operations. As examples, the original RBRVS assigned fewer relative value units (RVUs) to aortic aneurysms extending into the leg arteries than to those that did not, fewer RVUs to harvesting a preferable vein for bypass purposes in the leg than to a synthetic graft obtained from the shelf, and fewer RVUs to a difficult abdominal operation to prevent intestinal gangrene than to a synthetic bypass in the leg.

It has been a long and frustrating process to revise some of these basic mistakes, and others unfortunately still exist within the 1993 fee schedule.

We think the most important lesson to be learned from the Medicare RBRVS process is that vascular surgeons should have been directly involved with its development well before the time for its implementation. We are disappointed and deeply concerned with the impression apparently held by some policy makers that physicians, and specifically surgeons, are merely another "special-interest" group that should be held at arm's length in the deliberations regarding health care reform. This strikes us as a waste of professional and clinical expertise. Whatever conversion factor HCFA might have chosen to attach to it for reimbursement purposes, we are convinced that experienced surgeons could have constructed a legitimate set of relative values for vascular surgery in a fraction of the time and at a fraction of the cost that eventually was expended on the Medicare RBRVS. I suspect that every other surgical specialty could have done the same.

Vascular surgery, like many other surgical disciplines, requires years of additional training and a commitment to the care of high-risk patients with exceedingly complicated diseases. Through their national societies, vascular surgeons have repeatedly demonstrated their willingness to provide sound clinical advice regarding the development of an equitable RBRVS even within the constraints of a budget-neutral setting. We believe that an RBRVS-based system probably could be applied to broader health care reform, but only after considerable further revision. It just makes commonsense to involve surgical specialists from the onset in this kind of effort, and we hope that today's hearing means that our participation would be invited.

A Plan for Outcome Assessment

Now that Congress has begun to develop a consensus that will affect the health and well-being of every American, it is critical that full consideration be given to the quality of care, not just its cost. It would not be in anyone's best interests to initiate an economical program featuring mediocre care. My patients would never forgive me if I delivered less than my best to them, and I imagine your constituencies feel the same way. In this respect, what I am about to tell you is very important.

There is substantial reason to believe that the mortality and major complication rates for common surgical procedures are largely unknown at many if not most hospitals in the United States. Although national mortality statistics are available from a few sources (e.g., the Medicare database maintained by HCFA), this information is subject to errors in transcription, may fail to address serious nonfatal complications, and generally has not been employed either to enhance patient care or to facilitate credentialing decisions regarding the extension of surgical privileges where it counts -- at the local level.

Beyond the personal anguish they bring to patients who sustain them, substandard surgical results also are incredibly expensive. Take an unnecessary stroke after a carotid operation or an amputation after the failure of a leg bypass, for instance. Each of these leads not only to months of costly rehabilitation, but often to a lifetime of public financial support as well. Poor care is the most costly care of all, and the current crisis with respect to health care expenditures has focused considerable attention upon outcome research. Nevertheless, the absence of reliable local data in every hospital adds layers of complexity to these outcome projects and simply underscores the fundamental point that hospitals and their surgeons should document their own results. This principle is so elegant in its simplicity that it sometimes appears to be overlooked. Accordingly, the national societies in

the field of vascular surgery strongly recommend that the following proposal be incorporated into any plan for health care reform:

- The mortality rate and the incidence of certain complications for major operative procedures should be prospectively audited on a continuous basis at every hospital.
- The specialty society representing each surgical discipline should select three index procedures and their specific complications to be reviewed in these continuous audits.
- We believe it would be appropriate to test the feasibility of prospective audits with a pilot study in vascular surgery using the following parameters:

INDEX PROCEDURES SEVERITY CRITERIA OUTCOME MEASURES

Carotid endarterectomy	A. Asymptomatic stenosis B. Previous TIA C. Prior stroke	1. Mortality 2. Postoperative stroke
Abdominal aortic aneurysm resection	A. Asymptomatic aneurysms B. Intact symptomatic aneurysms C. Ruptured aneurysms	1. Mortality
Femoropopliteal and - tibioperoneal bypass	A. Claudication or ischemic rest pain B. Tissue necrosis/gangrene	1. Mortality 2. Amputation

These procedures seem especially suited to a prospective audit, and they comprise several of the most common operations in our field. This approach to outcome assessment already is employed by many conscientious surgeons in community practices as well as at academic centers, and it is entirely consistent with the principle of quality assurance in health care reform. As a matter of practical policy, our proposal would have several benefits:

- A number of reports have been published to indicate that surgeons who perform a low volume of certain operations, such as carotid endarterectomy or aortic aneurysm resection, appear to encounter more complications and worse mortality rates than surgeons who perform a high volume of the same procedures. In both Pennsylvania and Connecticut, for example, nearly half of the surgeons who perform carotid endarterectomy do only one or two of these demanding operations each year, and their postoperative stroke rates have been found to be much higher than those of other surgeons who have much more experience with this procedure.

Similar data also are available concerning hospital volume and outcome. While it would be very difficult for Congress to legislate appropriate volume, we believe it is quite likely that both surgeons and hospitals would voluntarily decline to perform "occasional" complex operations if their results are under peer review on the basis of prospective audits in their hospital.

- In addition to its obvious advantages for patients,

prospective outcome assessment would measurably enhance the objectivity of professional credentialling in every hospital. At the present time, disputes concerning the renewal of surgical privileges for specific procedures often deteriorates into a legal stalemate simply because no community standard has ever been established with which to compare the performance of an individual surgeon. Ongoing audits would help to determine, to the best interests of hospitals and surgeons alike, what those outcome standards should be.

- Unless health plan contracts of the future simply are to be given to the lowest bidder irrespective of the anticipated quality of care, buyers must have a real opportunity to consider outcome as well as cost in making their decisions. The approach we have recommended could provide this type of information on a continuous basis and should be applicable to the various reform proposals being considered by Congress.

Mr. Chairman, our proposal has nothing to do with the level of professional reimbursement. It is instead intended to encourage thousands of hospitals and surgeons to improve their quality of care and to reduce the tremendous expense of unrecognized complication rates. At this unique moment in our history, Congress, the Administration, and concerned doctors share the same goal of improving the quality and delivery of health care. You cannot do this alone, nor can we. Therefore, it is our hope that we can work with your Subcommittee in fashioning legislation that will provide for quality assurance and accountability.

Chairman STARK. Thank you.

I want to ask each of you the same question I asked the previous panel. Based on your personal experience in your own practice situation, without regard to the actual fee per procedure, but with regard to the issue of convenience and lack of complication or minimum hassle factor as it is referred to, could you each give me an idea of which plan or type of plan you might prefer?

Dr. Wilhite.

Dr. WILHITE. Yes, sir. I think any plan based on a relative value scale would be acceptable and appropriate for us.

Dr. JENSEN. There is no question with regard to paperwork and ease that Medicare is the easiest; if the patient has the card, you know they are covered. There is not as much hassle as one might assume. One of the problems with commercial payers is now there are so many different plans, you never know exactly what coverage the patient has in many circumstances.

Chairman STARK. Let me ask you this: Let us assume you just had Aetna preferred provider and Medicare. Are you saying that they are about the same in terms of retrospective review?

Dr. JENSEN. I think once you are sure what coverage the patient has and what plan they have, the private insurers work as well as Medicare does.

Chairman STARK. Dr. Bennett.

Dr. BENNETT. I will take a little different tack than everyone else this morning. We are a six person group. We contract with a variety of different payers. The easiest for us is a subcontract with a local HMO for specialty care, based on——

Chairman STARK. Is that a fee-for-service HMO?

Dr. BENNETT. A close second is the IPA. They pay us 125 percent of the relative value scale, on a capitative arrangement. We are tracking it.

Chairman STARK. Dr. Hertzner.

Dr. HERTZER. Mr. Chairman, 70 percent of our patients are Medicare, so we have relatively fewer other carriers. It is my understanding from our departmental administrator that the private carriers are a little bit less in the hassle problem and in that regard would be Blue Cross-Blue Shield in our area.

Chairman STARK. Are they also the Medicare intermediary?

Dr. HERTZER. Yes.

Chairman STARK. So either——

Dr. HERTZER. I believe that is true.

Chairman STARK. Do you have Kaiser in the area?

Dr. HERTZER. Yes.

Chairman STARK. How many referrals can you remember receiving in the past year from Kaiser's HMO?

Dr. HERTZER. Personally?

Chairman STARK. Yes.

Dr. HERTZER. Personally, probably three.

Chairman STARK. Do they have their own hospital?

Dr. HERTZER. They do. The Cleveland Clinic and Kaiser in Cleveland have recently signed an agreement that Kaiser will admit their patients to Cleveland Clinic, for care in our institution.

Chairman STARK. How about those HMOs that do not have that deal? Do they tend to keep their patients? Do you see fewer when they do not have a deal in your area?

Dr. HERTZER. We do not see very many from other HMOs. In my own situation, maybe reflected by the fact I am a surgeon, when I see a HMO patient, there is a lot of hassle factor with respect to ordering a test that would appear to me to be clearly indicated.

Chairman STARK. Dr. Silverman.

Dr. SILVERMAN. In my experience, the easiest to deal with are self-pay and commercial insurance. The HMOs, managed care plans, engender a tremendous amount of bureaucracy. We have had recently to add two people to our office staff to deal with these kinds of plans.

Chairman STARK. All right.

Thank you.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Dr. JENSEN, Dr. Bennett, I am deeply concerned about what impact the proposed plan would have on the inner cities, low-income people, and African-Americans. You stated that because of certain economic factors, and cultural factors, there is a high degree of diabetes, prostate cancer.

Could you elaborate?

Dr. JENSEN. I think the provision of universal access will be positive. Indeed one of our problems in the inner city is many of our citizens do not have insurance coverage. As you pointed out amongst African-Americans, glaucoma and diabetes are particularly more common and more serious from their standpoint than others.

So in that respect, I think there definitely will be a positive effect.

Dr. BENNETT. We certainly feel that universal access is important. However, I don't think the fact that anyone can get a card will mean they will go to a doctor. I think education, allowing the public to understand the need for a physician, is as important as the card itself. I think when you look at the uninsured, in quotes, that they—they are a changing group of people, that they are not always the same every year. I think that is a consideration. So we need to educate our public as well as give them a card.

I have already told you our concerns about prostate cancer; and we feel very strongly that whether you call it screening or early detection programs, that they are essential parts of health reform for our organization, and I would think for men as a whole.

Mr. LEWIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Dr. Silverman, I found your testimony to be quite interesting, if not unique.

Basically, I am paraphrasing, you indicate that the Federal Government is the cause of the medical health crisis in this country and the ever-increasing costs because we got into Medicare and Medicaid some years back.

Is that my understanding of your testimony?

Dr. SILVERMAN. No, sir. I think there are a variety of causes. The Federal Government, I think, is one of the causes, because the Federal Government is paying now for approximately 40 percent of health care in the United States; and what has happened with Medicare is that a population of people was guaranteed access to care and basically unlimited care without realizing the size of this population and the increase in technology to come down the road and what these costs would be.

What has happened is in order to control the Federal Government's spending, the government has said well, we are going to pay for a procedure x amount of dollars; maybe it is 30 percent, 50 percent, 60 percent of what that procedure actually costs. When that patient comes in, they are given that care; then a patient who comes in under the private system has to take up the costs.

There are a tremendous amount of cost shifting because of this that lead to increased costs. There are other factors. Obviously we need to increase costs. But I think this is one of them. You indicate insurance must be the responsibility of every individual not of corporations or the government.

The bulk of Americans today receive their insurance coverage through an employer-based system. Would you favor eliminating that?

Dr. SILVERMAN. I think what could be done is rather than having the employer pay for the insurance directly, they could give the employed the same amount of money they would be paying in premiums and it could be put in an account. The employee could then realize the benefits of buying insurance, tax deductibility; it would go to the individual rather than the corporation.

Mr. KLECZKA. The problem with that scheme is the younger employees would not put the dollars in health care because in their younger years they are more healthy. However, the rest of us in society do pay when that person becomes unhealthy. They never paid into the system.

I think your scheme or the IRA scheme which is part of some legislation introduced up here is flawed. Under the IRA scheme, if, in fact, you are an underemployed or a working poor person, you actually have money to put in a savings account versus a medical IRA, we want you to have an IRA for your home, and we encourage to you do an IRA for your employment.

Where are you going to get the funds for these IRAs including the medical area?

Dr. SILVERMAN. Certainly the plan is not without problem. What is happening today, there are a lot of young people opting not to buy insurance. They are part of the 25 million of people who are not insured. They are uninsured because of choice.

If you legislate and mandate everyone have insurance, I think the young people would be mandated into putting this money away for the plan. As far as people who are under the poverty level or do not have the funds, the Federal Government will have to set a certain limit they would allow to be put away.

They will have to subsidize that through a voucher system, some type of a system. It just seems to me the plan that is being proposed by President Clinton is a plan that has never been tried or tested anywhere. It is a plan that is based on computer models,

computer systems. We are proposing to take a health care plan that functions for over 85 percent of our population and throw it out the window and put in this plan and we have no idea whether it will work or what it will cost.

Mr. KLECZKA. Let me ask a final question.

Let's say the Clinton plan would pass in its entirety tomorrow. Would that affect your surgical clinic, Northwest Surgicare?

Dr. SILVERMAN. Conceivably, we could be put out of business if the managed care plans opted not to contract with us.

Mr. KLECZKA. Can't you compete price-wise?

Dr. SILVERMAN. Many insurance companies are forming exclusive contracts with the hospitals because they need the inpatient as well as outpatient service. The hospital says if you give us your outpatient business, we will give you a certain price on your inpatient business.

Even though we are providing lower cost quality care for 20 years before health care reform was a thought, we could be phased out of the picture. We are a center that the surgeons prefer to work at. There is much higher patient satisfaction. We operate more cost effectively and more efficiently. Basically we could be put out of business.

Mr. KLECZKA. Your opposition in part—I will not say how much—is self-interest; right?

Dr. SILVERMAN. No, I don't think so. I think it is in the interests of the patient. When you eliminate other choices, you hurt ultimately the consumer of health care. And not, you know, so much my surgery center or anyone else's business. You hurt the consumer of health care, the patient.

Mr. KLECZKA. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Are there other inquiries?

If not, I would like to thank the panel very much for their participation. We will be in touch with you as we go through this process over the next many months.

Our third panel includes representatives of six physician organizations, Leon Reinstein, president of the American Academy of Physical Medicine and Rehabilitation; Steven Van Camp, representing the American College of Sports Medicine; Melvin Sabshin, representing the American Psychiatric Association; Peter Cohen, representing the American Academy of Child and Adolescent Psychiatry; Stephen Cohen, president of the National Organization of Physicians Who Care; and Jonathan Javors, the medical director of the Centers for Health Excellence.

As with all the witnesses today, your testimony will be made part of the permanent record. You may proceed to summarize your statements in the order you were introduced.

We will start with Stephen Cohen.

STATEMENT OF STEPHEN C. COHEN, M.D., PRESIDENT, NATIONAL ORGANIZATION OF PHYSICIANS WHO CARE

Dr. STEPHEN COHEN. Thank you for the opportunity to testify. I am Stephen Cohen, president of Physicians Who Care, an organization that supports patients' rights to choose their medical care. I

am an oncologist and hematologist in the private practice of medicine in San Antonio, Tex.

A question that must be asked is will reform aid the healing process of our sick and keep our healthy well? The Clinton plan moves us toward a health care system radically different from the current one.

It is a system that would rely on so-called managed care and super HMOs. The so-called fee-for-service option found in the draft is more imaginative than a true alternative. The large majority of Americans currently receive their care through private practice physicians and the large majority of those people are very comfortable with their personal physicians.

Through a mixture of super-HMOs, price caps, low budgets and nightmarishly bureaucratic health alliances, a particularly pernicious mix has been put together that will reduce patient care and access.

The resulting corporate HMOs will seek profits with government pressure on one hand to keep costs down and pressure from patients for more and more benefits. The HMOs will need to cut care and find other ways to game the system. One way is to deny care to those who are seriously ill.

No, there will not be outright refusal of care but rather continuous delays in seeking care for specialists and adequate testing. In some HMOs, it is necessary for a patient to physically go back to his gatekeeper to get approval to assign their sub-specialists even though treatment may not be completed.

My full statement discusses the financial incentives to HMOs placed on primary caregivers, the so-called gatekeepers, to ration access to specialists and deny medical tests that are needed. In case you do not think this happens, let me give you two examples.

I know of an HMO patient who had seizures for 2½ years before a CAT scan was ultimately done that showed the patient had a brain tumor. I saw a patient with a head and neck tumor sent to a less well-trained specialist down the street. There was a cancer specialist, a cancer surgeon not consulted because of the implied costs.

Needless to say, the patient's cancer has recurred.

These huge HMOs will have unparalleled opportunity to cheat and game the system on the basis of caring for hundreds of thousands and more likely millions of patients. Corporate profits will take a front seat over patient care.

We should all have learned something from the recent scandals of the psychiatric hospitals, but I am afraid we have not.

Let me briefly turn to Medicare, a system which excellently served 34 million people. Unfortunately, it becomes a political football in times of budgetary constraints.

Is this what will happen under the government-run health care system outlined by the Clinton administration? The Clinton plan suggests that States will be able to put Medicare patients into these huge health alliances. Most elderly patients receive their care from private practice physicians, about 93 percent of all Medicare patients.

When seniors are told they cannot continue to see the doctors that they have been seeing for years, or they will have impaired

access to cardiologists or other specialists, the past storm of catastrophic health care will seem like a mild summer breeze.

In conclusion, let me discuss briefly some of the areas that need reform. People need security in health insurance which can be provided by portability and community rating.

Access for the uninsured needs to be enhanced. Costs need to be kept in line by having the patient and doctor both have a stake in these cost issues. This can be best served by Medi-save accounts.

In my written testimony I discuss more areas that need reform.

In the political rush to do something, do not trade a system that provides excellent care to millions of Americans for an untried radical approach that will overturn the right of choice to patients. Confidence between patient and physician is a vital part of the healing process.

Thank you.

[The prepared statement follows:]

**STATEMENT OF STEPHEN C. COHEN, M.D.
NATIONAL ORGANIZATION OF PHYSICIANS WHO CARE**

Good morning Mr. Chairman and members of the committee and thank you for this opportunity to testify. I am Dr. Stephen C. Cohen, President of the National Organization of Physicians Who Care, an organization that supports patients' rights including the right to choose one's medical care. I am an oncologist and hematologist in the private practice of medicine and Clinical Professor of Medicine at the University of Texas Health Science Center.

An auxiliary organization of Physicians Who Care is Patients Who Care which has more than 30,000 members throughout the country.

In looking at health care reform in this country and at the Clinton proposal in specifics, let me do the following in the course of my written testimony:

1. Discuss the Clinton plan as outlined in the famous draft document and some of the assumptions upon which it is based.
2. Discuss how the Clinton plan is going to make the storm over catastrophic a few years ago seem like a mild summer breeze for both Medicare recipients and all others who currently choose their own doctors.
3. Discuss the philosophy and approach of Physicians Who Care to health care reform that is based on discussions with hundreds of health care providers and thousands of patients.

I think that we would all agree that the bottom line of any health care reform must be how it will improve the health care of our citizens. Will health care reform aid the healing process for our sick and keep our healthy well?

1. The Clinton Plan

The Clinton plan moves us toward a health care system that is radically different from our current one. To some this will seem like I am stating the obvious, while to others it will seem that this is not true. But that ambivalent response is understandable once one realizes that there are two very different views of the Clinton plan by the Clinton Administration itself.

If you listened to President Clinton, Mrs. Clinton or most Clinton officials, you would think that the plan is built on choice by the individual of his or her plan and choice of doctors, on cutting costs without rationing services and on extending health care to millions now who don't have it. According to the Clinton Administration rhetoric, more Americans are going to have more health benefits without this costing more. In other words, more security for all Americans.

Unfortunately, my analysis of the plan shows something quite different. It is a system that would rely on so-called managed care and super-HMOs. The incentives in the plan all push toward managed care through HMOs.

Through a mixture of super-HMOs, price caps, global budgets and nightmarishly bureaucratic health alliances a particularly pernicious mix has been put together that will reduce patient care and access.

Government would be encouraging large insurance companies and other large corporations that will be running these HMOs to make a profit while lowering costs. If they do not do it on their own, premium caps will be imposed. This is in addition to the global budgets will result in even more pressure on HMOs to ration care. This is already done in a number of ways by many HMOs including restricting tests, not referring patients to specialists until medical problems have often become acute, and by requiring a number of visits to a gatekeeper over a period of time before tests are done or specialists are consulted. The result is a reduction in care.

Another issue also has to be considered. That is the financial incentives or disincentives that are placed on gatekeepers by many managed care plans. Under these incentives gatekeepers are able to share in the proceeds of a pool of money -- a so-called shared risk pool -- that results from less tests being ordered or specialists being referred to. The doctor is paid for providing less treatment. It is much like some of our farm programs where subsidies have been paid for not growing crops.

Of course, the whole concept of capitation in HMOs -- a payment on a per patient basis rather than what is done for the patient -- also rewards the physician for doing as little as possible for the patient. Such things as capitation payments and shared risk pools can lead to the interests of the patient being in conflict with those of his or her physician. Shared risk pools play on the greed of individuals rather than on what is the best for the patient. HMOs and other managed care providers should disclose to their patients and to the public what financial incentives are provided doctors to restrict services and to reduce referrals to specialists.

In case you think that these are only theoretical concerns, let me give you two examples from my own personal experience. I could give you dozens more.

I'm aware of an HMO patient who had multiple seizures for 2 1/2 years before his gatekeeper finally got him a CAT-scan of the brain which showed he had a brain tumor. I've seen a patient who had surgery for head and neck cancer by a less well-trained surgeon when a much more experienced surgeon was just a few doors away but wasn't consulted because of implied costs. This patient's cancer has recurred.

Next let us look at the major issue of choice. In HMOs patients are limited in their choice of their so-called primary care physician or gatekeeper -- they can only choose from those in the plan and those in the plan who are still taking additional patients. But their choice is even much more restricted than that. For they cannot even see a specialist or get a second opinion unless they first have the approval of their gatekeeper in the HMO. If they are then referred to a specialist, they have little or no choice in choosing who that specialist is as the patient will only be sent to specialists who are part of that HMO. There is no choice by the individual that he or she needs to see a specialist because that choice is not up to the individual. HMOs severely restrict choice. Choice of physicians at all levels should be a integral part of any reform package.

This restriction on choice can also lead to serious problems in continuity of care in the setting up of the Clinton health care system. People who are put into these regional health alliances have no guarantees that their current physicians will be part of the plan in which they are. This becomes a particularly acute issue for the seriously or chronically ill who are seeing a number of specialists for various conditions. The nightmares that could easily result could do serious harm to patients and their families.

Managed care as found in HMOs has, at best, a mixed record in quality of care issues and in cost issues. According to a study of the GAO and a CBO staff study, there is little evidence that HMOs hold down costs over the longer term. In matter of fact, several studies have pointed out that HMOs usually have healthier and younger patients who have less need of medical services and, as a result, keep costs down and do not overwhelm the HMO. Thus, cost savings may come from the type of individual who is enrolled rather than any other reason.

Looking at quality of care issues in an HMO setting also does not leave one sanguine. Numerous studies have shown that patients are usually happier when they are seen by physicians in smaller practices rather than in large bureaucracies. Such comfort levels are important because as any doctor can tell you a patient who doesn't have confidence in his or her physician is less likely to follow that physician's orders on medication and other treatment issues. We should never lose sight of the fact that healing is both an art and a science.

From my own practice, I know the problems that cancer patients have had with HMOs in getting referrals to specialists and in getting proper care. The view among many observers is that HMOs are fine as long as you are healthy.

A Clinton Administration official would argue that this is all meaningless because patients do have a choice. There will be fee-for-service alternatives. Unfortunately, the so-called fee-for-service option found in the draft is much more a fig leaf than a true alternative:

1. The National Health Board can rule that no fee-for-service alternatives need be allowed. There could be whole states with no fee-for-service plans.
2. The health alliances can decline to include any plans that cost 20 percent more than the average price of other plans that it offers.
3. Patients who choose a fee-for-service alternative, assuming for the moment it is available, will probably have to pay higher premiums and greater out-of-pocket costs.
4. Under something called "prospective budgeting", states could tell alliances that they can develop or allow only one fee-for-service plan which would have an annual budget to which it would comply. Utilization review and payment adjustments would be used to make sure that budgets were not exceeded. A fee-for-service plan or, in other words, a private practice plan had better not have too many very ill patients in it or it would be quickly rationing care to its members or be out of business.

In many ways, the fee-for-service alternative is simply an HMO in drag.

As I said, the Clinton plan is a radical departure from our current system. Unfortunately, it seems that one of its basic underlying assumptions is the rationing of care.

2. The Clinton Plan and Medicare

Millions of Americans depend on Medicare. While the Medicare system does have problems, it has provided excellent treatment. It does become a political football in times of budgetary problems. Is this what will happen to a government-run health care system as has been outlined by the Clinton Administration?

The Clinton plan suggests that states will be able to put Medicare patients into these huge health alliances or health insurance purchasing cooperatives. Remember what I said earlier -- the large majority of Americans receive their medical care from private practice physicians. This is even more true of those on Medicare. The vast majority of Medicare patients receive their health care from private practice physicians -- the numbers that I have seen are about 92% to 93%. When seniors are told that they cannot keep seeing the doctors they have been probably seeing for years nor can they go to their favorite cardiologist or other specialist, the past storm over catastrophic will seem like a mild summer breeze.

Our citizens on Medicare understand the importance of patient choice to their own well-being. If they don't like a particular physician, they go see others. This freedom of choice would be severely restricted in the system that would be created by President Clinton in his American Health Security Act. If fee-for-service alternatives were severely restricted as I pointed out above, a guarantee to Medicare recipients that they could see their own physicians would be meaningless as that option would no longer exist in reality.

3. Elements of True Reform

While Physicians Who Care has some major points of concern and disagreement with President Clinton's proposals, Physicians Who Care does support reform of the current health care system.

People need security in their health care insurance. Portability needs to be built in and some type of community rating is needed.

Simplification of insurance forms is important for both the patient and the physician. In this time of technology, a single form for all plans should be able to be developed.

Malpractice reform will also help patient and physician. It will help reduce costs on several levels. But malpractice reform must be real.

Rapid advances in technology have added to costs as has the aging of the American population. Health care reform should not discourage future advances in technology that holds out the hope of cures for many of the diseases of today.

Access for the uninsured must be enhanced. This can be done through a mixture of subsidies, high deductible policies and Medi-save accounts.

Costs do need to be kept in line. To do this both the patient and doctor must have a stake in cost discussions. One way to help accomplish that is through Medi-save accounts. Along with Medi-save accounts, high-deductible policies can help reduce costs.

Health care reform is necessary. In the political rush to do something don't destroy a system that currently provides care to millions of Americans for an untried, radical departure that would overturn the rights of patients to choose their doctors at all levels and their medical care. Health care reform needs to have as a basic concern the rights of patients and give them the power to make more choices rather than less.

Confidence between patient and physician is a vital part of the healing process. Let's not destroy that.

Chairman STARK. Dr. Reinstein.

**STATEMENT OF LEON REINSTEIN, M.D., PRESIDENT,
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND
REHABILITATION**

Dr. REINSTEIN. Mr. Chairman, members of the committee, ladies and gentleman, I am Dr. Leon Reinstein, president of the American Academy of Physical Medicine and Rehabilitation; 4,000 physicians who specialize in the care of people with physical disabilities and chronic disabling illnesses such as stroke, spinal cord injury, brain injury, amputations, chronic pain, cerebral palsy, and multiple sclerosis.

I work at Sinai Hospital in Baltimore and live and vote in Representative Cardin's district.

President Clinton's plan to reform America's health care system goes a long way toward addressing many of the problems of the current system which discriminate against persons with physical disabilities and chronic disease. In my few minutes, I would like to focus upon six areas as they relate to persons with physical disabilities and chronic disease: Coverage, scope of benefits and services, eligible plans and choice, medical education, financing, and purchasing alliances.

First, coverage. Principals of national coverage in President Clinton's proposal would have a positive impact on patients with disabilities since coverage would be available to all Americans. It would prohibit preexisting condition exclusions, cherry-picking, blacklisting, redlining, all practices of the insurance companies which are a national disgrace. It would afford long overdue coverage and rating insurance reform.

Second, scope of benefits and services. The proposal includes a broad array of services relating to the rehabilitation of patients with physical disabilities.

Third, eligible plans and choice. The Academy strongly supports real choice for patients with physical disabilities who often need specialized services from specially trained physicians. We strongly recommend that the HMO and network options include a right for persons with physical disabilities and chronic illnesses to select a primary physician or gatekeeper from among a panel which includes specialists.

Typically, many of these patients have received their primary care from such a person in the past. These patients have specialized care problems unique to their disability which can be better managed and managed less expensively by a physician with specialized knowledge. Many primary care physicians are not comfortable or knowledgeable to care for these patients.

Fourth, medical education. Physical medicine and rehabilitation is a shortage field of medicine. GMENAC concluded we would need 4,000 specialists in PM&R by 1990. It is only now 3 years later we have reached that number. With the aging of the population and high tech medicine producing many more survivors, there should not be a reduction in residency positions in physical medicine and rehabilitation.

Fifth, financing. We are concerned that the Medicare and Medicaid savings which are to finance health care system reform will

place limitations on services to the elderly and to the poor. Medicare and Medicaid currently are loss leaders for most hospitals and physicians. How much more can you cut?

Sixth, purchasing alliances. Simplicity is one of the six principles of the Clinton plan. The proposed purchasing alliances will, in fact, add complexity and bureaucracy rather than simplify. Isn't it ironic the Clintons want to create a system of mega for-profit insurance companies to solve the problems of simplicity and savings which are in large measure due to the avarice, greed, and practices of these same for-profit insurance companies?

In summary, the American Academy of Physical Medicine and Rehabilitation supports universal coverage through insurance reform, guaranteeing availability of physical medicine and rehabilitation services to all Americans with physical disability and chronic disease; strongly recommends that choice include the choice of physical medicine or rehabilitation specialists to be primary care gatekeepers for patients with chronic disease and physical disability; strongly urges that physical medicine and rehabilitation residency positions not be decreased because of the current shortage and future need for PM&R physicians; has great concern about the funding mechanisms with major reductions proposed for Medicare and Medicaid; and finally, we are greatly concerned that purchasing alliances will add to the bureaucracy and complexity of the health care system.

America's health care system needs to be fixed. Let's work together to fix it right.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF LEON REINSTEIN, M.D.
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION**

Mr. Chairman:

The American Academy of Physical Medicine and Rehabilitation is a national medical specialty society of more than 4000 physical medicine and rehabilitation physicians, whose patients include people with physical disabilities and individuals with chronic, disabling illnesses such as spinal cord injury, brain injury, amputations, stroke, chronic pain, musculoskeletal impairments, cerebral palsy, and multiple sclerosis. The Academy believes that lack of access to appropriate health insurance coverage and resources for physical medicine and rehabilitation services greatly limits opportunities for persons with disabilities. Persons with disabilities have often been refused health insurance because of pre-existing conditions, have had to accept inadequate coverage, and have been most threatened by loss of coverage.

President Clinton's plan to reform the nation's health care delivery system goes a long way toward addressing many of the problems in the current system which discriminate against people with disabilities. However, the Academy believes that any system that relies heavily on delivery of services through managed care needs to include protections against underservice of those with severe chronic and disabling conditions. The President's proposal seems to rely heavily on managed care and does not provide for adequate choice of providers or protections against underservice.

Coverage

The principles of national coverage in President Clinton's proposal would have a positive impact on people with disabilities since coverage would be available to all individuals. The proposal would prohibit pre-existing condition exclusions, and would extend health care to all Americans regardless of income. The President's proposal would also assure portability of coverage and community rating of premiums, both of which are necessary reforms to enable persons with disabilities to have access to necessary health insurance.

Scope of Benefits and Services

The proposal would also have a positive impact on persons with disabilities because it includes a broad array of services related to the rehabilitation of patients with physical disabilities. We support in particular the inclusion of the following coverage: (a) inpatient medical rehabilitation services that are properly organized, goal directed and furnished in residual settings; (b) properly organized, goal directed outpatient medical rehabilitation services in all appropriate settings; (c) professional services of physicians including physical medicine services for treatment of musculoskeletal, neuromuscular or other conditions; and nonphysician services as authorized by Medicare law including services of psychologists; (d) prosthetic and orthotic devices and essential durable medical equipment; (e) home care such as nursing, physical therapy, occupational therapy, and speech and language therapy; (f) patient education in self-care and preventive measures for persons with disabilities and chronic illness. Such preventive measures are intended to prevent complications and secondary disabilities such as skin problems and infections. Rehabilitation coverage should be related to the goals of improvement in function over time or the prevention of deterioration in function or loss of function over time.

It is the Academy's interpretation of the Proposal that these services are included in it, and we applaud their inclusion. We also support the inclusion in his Proposal of prescription drugs.

The Academy also strongly endorses the inclusion of a long-term care program such as recommended by the President. The lack of community and home based services for persons with disabilities which limit their activities of daily living has long been a serious problem with our national health care services in the United States.

Finally, we support catastrophic protection such as that proposed by the President. We believe the catastrophic thresholds of \$1500 and \$3000 are too high for low and moderate income people however. This is a serious problem since the important principle of "choice"

is conditioned by very high copayments which many people of modest means cannot meet. Their choice of "their own doctor" will not be a real choice. In order to further real choice of providers, we recommend that the catastrophic thresholds be income related to further encourage choice. A lower income family of four could have a \$1500 protection while a family earning \$200,000 could have a \$4500 protection for example.

Eligible Plans and Choice

Though fee for service plans may be available, their availability is unnecessarily limited. Why should any fee for service plans be singled out for elimination from the competitive process and why should federal law impose rigid copayment requirements of 20% on all services? The cost of copayments is very high making such plans out of the reach of many Americans, and of most Americans who have disabilities. We have heard many individuals with disabilities express concern to us about this aspect of the President's proposal and about the inadequacy of services for persons with physical disabilities in HMOs and managed care systems.

The Academy strongly support real choice for consumers, particularly persons with physical disabilities, who often need specialized services from specially trained professionals. That choice will not be real until the copayment obligations for the plans which allow choice of providers are reduced for individuals with limited financial means, particularly those who also are persons with disabilities.

We also strongly recommend that the HMO and managed care options include a right for persons with disabilities and chronic illness to select a primary physician and "gatekeeper" or case manager from among a panel which includes specialists. Each plan should be obligated to establish panels of physicians, including specialists, from which consumers with disabilities of chronic illness can choose their care manager. A person with cerebral palsy, spinal cord injury or brain injury may desire to have care managed by a specialist such as a specialist in physical medicine and rehabilitation rather than by a generalist. This will often be the case where such care has been managed by specialists in the past, where the physician contact will be most frequently with these specialists or where the condition is such that the specialist is able to deal with general needs as well as specialty needs more effectively than the primary care physician. Physicians with specialized knowledge of conditions also know much more about the services and resources needed by the patient with a disability. They may order fewer tests and know better when services aren't working and should be terminated. We think that the best way to deal with potential problems of over use of services is not by plan limits on the number of services or gatekeepers whose incentives are to underserve. The best method is the use of appropriately developed practice guidelines by all plans.

Our current methods of furnishing health care are inadequate in providing for the primary care needs of persons with physical disabilities. This failure has resulted in significant, unnecessary rehospitalization for preventable conditions such as urinary tract infections and skin problems. Specialists in physical medicine and rehabilitation often provide primary care for persons with physical disabilities in both inpatient and outpatient settings. Frequently, this is because general primary care physicians are not comfortable with the management of primary care for a brain injury, spinal cord injury, or cerebral palsy. Often the routine medical or primary care problem is related to the disabling condition in a significant way and requires specialist management.

Medical Education

As graduate medical education policy is made, the needs of persons with physical disabilities for appropriate primary care must be recognized. There should not be reductions in positions for the training of specialists in physical medicine and rehabilitation.

Financing

We are concerned that the Medicare and Medicaid savings which are to finance much of "reform" will not reform and improve services for the elderly and persons with disabilities who are eligible for Medicare. It is unclear what specific levels of cuts are being considered nor are we clear about the extent to which these savings are financing expanded Medicare benefits. The Academy feels that further Medicare and Medicaid cuts, as opposed to savings obtained because health care reform will now cover services formerly covered by Medicaid, are not appropriate for financing health care reform. Health care reform should enhance coverage and services for all Americans. We think that Medicare has borne many cuts in the last decade to reduce the deficit. It cannot also bear the level of cuts we believe are recommended by the President.

Purchasing Alliances

We are concerned about proposals which make the administrative system more complex rather than simplifying the administration of health insurance and services. The Alliances proposed seem very complex and involve major expenditures for new bureaucracy. We are adding Alliances, to the Health Care Financing Administration, state agencies for Medicaid and insurance, and health insurance carriers all of which regulate the economics and practice of medical care. While the concept of cooperative purchasing for small business and individuals may be a reasonable way to reduce the price of insurance for consumers, including persons with disabilities, the Alliance system proposed by the President seems large and complex.

We would be happy to answer any of your questions and we thank you for providing us with this opportunity to testify.

Chairman STARK. Dr. Van Camp.

STATEMENT OF STEVEN VAN CAMP, M.D., FELLOW, AMERICAN COLLEGE OF SPORTS MEDICINE

Dr. VAN CAMP. Mr. Chairman, subcommittee members, I am Steven Van Camp, a cardiologist from San Diego where I have been in private practice for the past 15 years. This morning I represent the American College of Sports Medicine, the oldest and largest sports medicine and exercise science organization in the world. We have over 14,000 members from the fields of medicine, basic and applied research, allied health and education.

Our mission is to promote scientific research and practical applications of sports medicine and exercise science for the purpose of improving health and fitness. The American College of Sports Medicine applauds the White House health care reform proposal, as well as others, that call for guaranteed health care coverage for all. However, for this worthy goal to be achievable and affordable, a greater focus on and investment in prevention must occur.

We know that the lack of physical activity or a sedentary lifestyle contributes to more than 250,000 deaths in the United States each year. Physical inactivity has been classified by the American Heart Association as an official risk factor for coronary heart disease along with smoking, high blood cholesterol and high blood pressure.

Additionally, sedentary individuals are more likely than their active counterparts to develop high blood pressure, noninsulin dependent diabetes, osteoporosis, colon cancer and mental health problems. The American College of Sports Medicine strongly supports the development of effective national health initiatives to promote physical activity in the U.S. population.

Prevention activities are affordable and need to be essential and mandatory parts of reforming our health care system. Whereas procedure-oriented prevention measures such as immunizations and mammography are important, they are only a part of the much larger disease prevention picture.

For a program to be truly one of disease prevention, it must include the promotion of healthy lifestyles. Without a strong health promotion disease prevention component in health care reform, including emphasis is on physical activity, this country will initiate an unavoidable and unaffordable cycle of paying even more to treat chronic health problems that lifestyle changes could have prevented in the first place.

In our written testimony we have included specific recommendations including reimbursement, research, health promotion activities, professional education, and the establishment of a Federal office of physical activity and health. We hope these recommendations will be carefully considered by this subcommittee.

In conclusion, we believe it would be a terrible mistake not to invest in a systematic program of prevention and education, emphasizing active and healthy lifestyles. Without a strong health promotion disease prevention component, meaningful health care reform will be virtually impossible. Moreover, it will certainly prove to be a historical challenge to the financial health of this great country.

I appreciate the opportunity to present the American College of Sports Medicine's statement to your subcommittee. We will be extremely happy and willing to provide any further information or work with you in any way you wish.

[The prepared statement follows:]

**The Role of Physical Activity and Prevention
in**

Health Care Reform in the United States

presented by:

Steven Van Camp, M.D., FACSM

on behalf of the

American College of Sports Medicine

to

Members of the House Ways and Means Subcommittee on Health

October 26, 1993

Introduction

The American College of Sports Medicine (ACSM) is the oldest and largest sports medicine and exercise science organization in the world and is renowned for its leadership in fitness-related research and application. It is dedicated to the maintenance and enhancement of health, quality of life, fitness and physical performance, which is accomplished through the promotion and integration of scientific research, education, and practical applications of sports medicine and exercise science.

ACSM works closely with other organizations and federal agencies to develop recommendations for improving health that are effective yet realistic and affordable. ACSM applauds the White House Health Care Reform proposal, as well as others, that calls for the guarantee of health coverage for all. However, for this worthy goal to be achievable and affordable, a greater focus on and investment in prevention must occur.

The health benefits from physical activity are so enormous that ACSM has developed internationally accepted precise guidelines and formulas for "exercise prescriptions." These prescriptions can be many times more effective than other types of treatment. One example is ACSM's newest position statement on exercise and hypertension (high blood pressure). The statement promotes physical activity as an effective alternative to drug therapy for patients with mild to moderate hypertension.

With the combined expertise of over 14,000 members of the leading physicians, basic and applied scientists, allied health professionals, educators and others in the field, ACSM is in an expert position to assist with and testify on the positive and preventive effects physical activity can have on the nation, particularly with regard to health care reform.

The Importance of Physical Activity as a Means of Disease Prevention

Prevention is affordable and needs to be an essential and mandatory part of reforming our health care system. Unfortunately, an obvious lack of attention is being paid to increased physical activity as a viable and economical form of disease prevention. The focus of the present plan instead is on procedure-oriented prevention including immunizations, mammograms, and physical examinations. Whereas these services are certainly important, they are only one small part of a much larger disease prevention picture. For a reform program to prevent disease, it must include the systematic promotion of healthy lifestyles, which would include increased physical activity, smoking cessation, better nutrition and restrained alcohol consumption. Without a strong health promotion/disease prevention component, health reform could quickly become unaffordable. Furthermore, it would provide no incentives for employers, organizations and individuals to take proactive steps to promote health and prevent disease.

Promotion of increased physical activity as a means of disease prevention must become an integral part of health reform. Physical inactivity contributes to more than 250,000 deaths each year, equal in magnitude to other chronic disease risk factors such as smoking, high blood cholesterol, and high blood pressure. Indeed, based on a preponderance of evidence, the American Heart Association now lists a sedentary lifestyle as an official major risk factor for coronary heart disease. Epidemiologic studies presented in recent ACSM scientific meetings and in publications, along with ACSM-member research show that sedentary individuals are more likely than their physically-active counterparts to develop:

Coronary heart disease
 Hypertension (high blood pressure)
 Non-insulin dependent diabetes
 Osteoporosis
 Colon cancer
 Mental health problems

Conversely, higher levels of physical fitness and habitual physical activity are associated with lower all-cause death rates. The conclusions of this epidemiologic research is supported by a large number of experimental studies showing that exercise training improves coronary heart disease (CHD) risk factors and other health-related factors including: blood lipid (cholesterol) profiles; resting blood pressure in persons with mild to moderately high blood pressure; body composition; glucose tolerance; bone density and depression.

Despite the overriding evidence that physical activity can reduce the risk of chronic disease, only 22 percent (less than one in four) adult Americans are active at the level recommended for health benefits. Conversely, 24 percent of the nation's adults are totally sedentary and the remaining 54 percent are inadequately active. The lack of physical activity is also higher in minority ethnic groups, the less educated, those of lower socio-economic status and older adults--the same population groups in which chronic disease is most prevalent.

In short, physical inactivity is a major chronic disease risk factor that crosses all demographic boundaries at epidemic proportions. Fortunately, unlike other risk factors, physical inactivity can be easily and economically avoided. Yet federal health agencies and existing and proposed health care policies give very little attention or support to physical activity and its proven preventive health benefits. Just 30 minutes of physical activity over the course of most days of the week can have the same positive effect on health as smoking cessation, one of the main prevention focuses of health care reform.

The Financial Impact of Increased Physical Activity

The American Institute of Preventive Medicine has issued the following statistics on the financial impact of physical activity:

- (1) Prudential Insurance's 5-year study of 184 employees who participated in a worksite fitness program showed that:
 - Major medical expenses dropped by 46%.
 - Participants experienced 43% fewer disability days.
 - Physically fit employees took three and one-half fewer sick days a year than other employees.

Source: Journal of Occupational Medicine, 1984, Vol. 26
- (2) Scoular Grain, a company of 600 employees in Omaha, Nebraska found:
 - Since opening its fitness center in 1989, health care costs were reduced by over \$1 million or about \$1,500 per employee.

Source: Wellness Councils of America
- (3) General Electric in Cincinnati, Ohio showed that:
 - Employees who exercised were absent from work 45% fewer days.

Source: Wellness Councils of America
- (4) A cardiac rehabilitation program at Coors Company demonstrated:
 - 180 post-coronary employees showed a savings of \$1.4 million over six years.

Source: American Journal of Health Promotion, September/October, 1989, Vol. 4, No. 1

The American College of Sports Medicine Recommendations

- (1) ACSM strongly supports the development of effective national initiatives to promote physical activity in the U.S. population; such initiatives have the clear ability to prevent disease and disability, thereby reducing health care costs. Specifically, those initiatives as they pertain to the national health care policy proposal include:

- a. *Appropriate reimbursement for primary care physicians and health care professionals who counsel patients on the benefits of physical activity:* ACSM recommends that physicians and other health care professionals routinely counsel all patients on the benefits of physical activity and encourage the majority of patients to adopt and maintain a physically-active lifestyle suitable to their needs. Studies have shown that physicians can be effective authority figures in changing patient behavior. The large number of primary care physicians and the frequency with which Americans visit their doctors suggest that even a modestly effective physician counseling program could have substantial public health benefit.

For that reason, time-intensive activities such as physical activity counseling, cardiac rehabilitation and preventive exercise sessions need to become reimbursable charges or a standard part of pre-paid services within the prevention component of any health care reform legislation. Training for health care professionals on the role of physical activity and use of exercise prescription in health promotion and disease prevention should be a key component in the transition to the new health care system.

- b. *Expanded funding of research to study the effects of physical activity as a means of disease prevention and health promotion:* ACSM strongly advocates an expansion of funding through the National Institutes of Health (NIH) for prevention research, and specifically the studies of the roles physical activity plays in the public's health. The College solidly supports and applauds the NIH for hosting conferences such as the recent "Disease Prevention Research at NIH: An Agenda for All," attended by both federal and private agencies. The meeting cited physical activity as a major component in recommendations for future funding of prevention research. Specifically, physical activity was one of only ten conference topics that were highlighted for individual workshops to develop specific research strategies for health promotion and disease prevention. More federal funding must be invested in physical activity research.
- c. *Increased emphasis on health promotion activities such as public information and education:* ACSM believes that public information and education efforts should be core functions of public health programs. National campaigns should be waged to elevate the public's awareness of physical activity and preventive health. The reduction of disease risk factors, and specifically physical inactivity, cannot occur unless the citizens are keenly aware of the risks they face due to their inactive lifestyles. They must be properly motivated and rewarded to change their behavior.
- d. *Encouragement of public health agencies, schools and other organizations to implement effective health promotion strategies for the nation's various populations:* The health of the nation requires a strong alliance among the education, public health and the reformed health care delivery systems. ACSM concurs that informing and educating health care providers about their roles in preventing disease is vital to the success of the reforms. An equally important component of the education and information process is medical and allied health school curricula that include instruction in physical activity and proper nutrition.
- e. *Increased professional education efforts geared to health care providers:* As the health care delivery system adds more primary care and non-physician practitioners, they need to be expertly trained in exercise prescription as a viable means of disease prevention. They also need to be trained in the positive effects that physical activity can have on persons suffering from chronic disease.

f. Increased physical activity training for all health care providers:

ACSM recommends that specialists in the fields of preventive and clinical exercise be included in the White House-proposed "health professions' special projects and demonstration training authority" to ensure that physical activity is part of all training curricula.

- (2) Due to the extremely important role of physical activity in disease prevention and good health in general, as well as the success of health care reform, the American College of Sports Medicine urges consideration be given to creating a Federal Office of Physical Activity and Health to undertake the following activities:
- a. To plan and implement a national public education program for professionals and the public-at-large on the benefits of increased physical activity;
 - b. To ensure the issuance of a Surgeon General's Report on Physical Activity and Health;
 - c. To support research on public health promotion and public health implications of physical activity, and coordinate the pertinent research activities of various federal agencies;
 - d. To conduct ongoing surveys of physical activity participation in the U.S. population;
 - e. To support model programs for promotion of physical activity;
 - f. To support relevant scientific and clinical meetings on physical activity and exercise science.

Conclusions

If health care reform is to be truly effective and cause the least amount of financial burden on the nation's citizens, it must include a strong disease prevention component. But it must be a complete prevention plan, and not one that focuses solely on procedural prevention such as immunizations, mammography and prenatal care. While these services are extremely important, prevention *also* has to be inclusive of lifestyle matters and life choices such as physical activity. Health care reform as well as the health of the nation would be impaired without such a comprehensive approach to prevention.

Our citizens need to recognize that lifestyle choices, such as engaging in regular physical activity, are critically important to health and that a sedentary lifestyle is a major *cause* of disease. While so much attention has been paid to other risk factors, such as high cholesterol and smoking, lack of physical activity has often been overlooked yet it is just as dangerous. More than 43 studies have demonstrated that persons who are sedentary are at almost twice the risk for coronary heart disease as their physically active neighbors.

The American College of Sports Medicine has played a leadership role in helping to change sedentary lifestyle patterns as demonstrated by a public health statement issued last summer, with the U.S. Centers for Disease Control and Prevention in conjunction with the President's Council on Physical Fitness and Sports. Together, the three organizations issued new guidelines on the importance of physical activity for health and initiated a national health promotion program lead by ACSM.

ACSM will continue its mission to make Americans aware of the benefits of physical activity and its profound impact on disease prevention. The government must play a major role as well. The American College of Sports Medicine cites the following components in the proposed health care reform package as starting points:

- Inclusion of appropriate reimbursement for physical activity counseling and cardiac rehabilitation by physicians and health care providers;
- Expanded funding for scientific research to study the benefits of increased physical activity on the population as a whole including those with special needs;
- Increased emphasis and support for public information and education as core elements of a national awareness campaign and public health out-reach programs;

- Emphasis on professional education to include physical activity for those training or retraining to become primary health care providers;
- Appointment of specialists in the fields of preventive and clinical exercise as members of the proposed "health professionals' special projects and demonstration training authority."

As a means of implementing these programs, ACSM urges the formation of the Federal Office of Physical Activity and Health to ensure the physical activity objectives of these programs are scientifically and appropriately met, and to coordinate the efforts of other government entities involved with physical activity. The potential of the federal role in this area is enormous and must be better coordinated and more effective.

After more than three decades of a steady increase in the numbers of Americans engaging in physical activity, the number has plateaued--a disturbing and potentially harmful trend. But the attention of the nation and its government is turning towards effective means of disease prevention and health care reform. This is a timely opportunity to prevent further declines in physical activity and promote better health of our nation by initiating vigorous plans to get America moving again. It would be a terrible mistake not to invest in a systematic program of prevention and education, and to reward employers, organizations and individuals who promote and engage in healthy lifestyles. Otherwise, the American College of Sports Medicine believes the nation will have a health care system that rewards poor health habits. Without a strong health promotion/disease prevention component, meaningful health care reform may be virtually impossible. Moreover, it will certainly prove to be an historical challenge to the *financial* health of this great country.

Chairman STARK. Thank you.

**STATEMENT OF MELVIN SABSHIN, M.D., MEDICAL DIRECTOR,
AMERICAN PSYCHIATRIC ASSOCIATION**

Dr. SABSHIN. Mr. Chairman, members of the subcommittee, I am Melvin Sabshin, medical director of the American Psychiatric Association. We are the medical specialty representing 38,000 psychiatrists in the United States. My written testimony has been submitted for the record and includes a fairly extensive analysis of our understanding of the President's September 7 draft proposal.

In my prepared statement, we indicate our many areas of agreement with the proposal, but at the same time we indicate areas of significant disagreement. What I would like to do this morning is focus on three areas of concern to us.

First, the residual stigma against people with mental illness; second, some of the issues about graduate medical education; and third, some of the managed care issues within the program.

In his September 22 address, President Clinton said the Nation "can no longer afford to ignore what is wrong with our health care system." But for the millions of people who suffer from mental illness, what is consistently wrong is that the health care system treats persons with mental illness differently from those with physical illness because stigma exists.

In the proposal that has come out of the Clinton administration, at first there appeared to be a historical attempt to reduce the stigma and provide care for those with mental illness, the same basis as those with physical illness. But as the plan developed suddenly, a variety of inhibitions were placed within the program which imposed discrimination once again.

We believe very strongly that persons with mental illness and their treating physicians and other health professionals should be subject to the same protocols, the same cost controls, and the same reviews as required of patients with nonpsychiatric illness.

That is our plea throughout this testimony. They should treat us in the same way. And the executive branch has not done that.

We hope we can work with Congress to change this.

The graduate medical education issues are the same you heard in a number of other areas of testimony.

We recognize the need for more primary care physicians; but psychiatrists are the primary care physicians for those with mental illness; and we have been designated, as have others, as a shortage specialty. We ask that in your deliberations you pay attention to the shortage specialties. We also hope you will see if there can be ways to indicate that people in these shortage specialties might be induced to work in jails and prisons and other contexts where there is a strong shortage and a need in this country.

Much of my testimony deals with managed care. We want to stress the point that properly designated and implemented, the job of managed care is to ensure patients receive medically appropriate care; and an effective, managed, competitive system should be able to deal with that without setting arbitrary limits on treatment. It is those arbitrary limits I am testifying against.

Psychiatric patients should receive the medically appropriate care in the most appropriate setting for their treatment. No more,

no less. We ask you to consider that strongly. Based on our experience, we hope that you will write into the Federal law clear-cut national standards to ensure management of care does not become arbitrary denials.

We do have a draft bill that would accomplish that. We would be delighted to work with you and your staff on that draft bill.

We have also in development practice guidelines that will help in the evolution of these standards.

We submit to you, Mr. Chairman, that appropriate development of psychiatric care would have large cost savings over and over again. We have indicated the offset studies that show nondiscriminatory psychiatric benefits could save as much as \$100 billion.

The President, Mrs. Clinton, and Mrs. Gore are to be commended for their efforts to phase out discrimination against persons with mental illness. We urge you in Congress to work for the same goal.

We would be happy to cooperate with you in any way that we can.

Thanks for this opportunity.

[The prepared statement follows:]

Statement of the American Psychiatric Association
 On:
Coverage of Treatment for Mental Illness in Health Care Reform
 Presented to
 The House Ways and Means Subcommittee on Health
 by
 Melvin Sabshin, M.D.
 Medical Director
 Tuesday, October 26, 1993

Mr. Chairman, I am Melvin Sabshin, M.D., Medical Director of the American Psychiatric Association (APA), a medical specialty society representing more than 38,000 psychiatric physicians in the United States.

The efforts of the Clinton Administration, and the continuing efforts of the Congress and particularly yourself and members of the Health Subcommittee, to reform the nation's health care system pose a unique opportunity for redressing discrimination against persons with mental illness (including substance abuse) and for ensuring -- once and for all -- that those who suffer from these illnesses have access to the care their illnesses require for effective treatment.

Sadly, discrimination against persons with mental illness is an ingrained aspect of American culture. It desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like the millions of Americans who suffer from heart disease, cancer, or diabetes. By dehumanizing the victims and denigrating the illness, it also facilitates discrimination in health insurance coverage for persons with mental illness.

The APA's recommendations for health care reform are stated simply:

- We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness and those who treat them.
- Coverage of treatment for mental illness should be included as a uniform health benefit in any health care reform proposal, subject only to the same scope and duration as are applied to non-psychiatric medical illness.
- Persons with mental illness -- and their treating physicians and other health professionals -- should be subject to the same protocols, the same reviews, and the same cost controls as are required of patients with non-psychiatric medical illnesses and the physicians and other health professionals who treat them.
- We recommend consideration of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.
- Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, and home- and community-based services, as the patient's clinical needs require.
- In order to ensure that the clinical needs of patients with mental illness are properly addressed, care should be taken to ensure that there is a sufficient supply of psychiatrists, who are the only physicians specifically trained in the diagnosis and treatment of mental illness, and the only "mental health" providers who are physicians.

More than any other medical doctor, psychiatrists know first hand about the health insurance crisis affecting the United States. As the only physician specializing in the "primary care" of treatment for persons with mental illness, we are confronted every day by the fact that many of our patients effectively have no health insurance, particularly if they suffer from "severe" mental illness.

Our insured patients face discrimination in the form of higher coinsurance or different arbitrarily established limits on inpatient or outpatient coverage duration for their mental illness than is otherwise applied to other non-psychiatric medical illnesses. Many patients because of stigma refuse to use the insurance coverage they have out of fear of being denied health insurance if they ever change jobs.

Even the Federal Government is guilty of "discrimination by diagnosis." More than 30 years after the enactment of the Medicare program, our nation's senior citizens and disabled Medicare beneficiaries must still pay out of their own pockets 50 cents of every dollar for outpatient care by a physician psychiatrist, clinical psychologist, or clinical social worker. This is direct and blatant discrimination by the Federal Government against persons with mental illness. APA has worked for many years to end the 50 percent Medicare outpatient mental health coinsurance requirement, and we urge you to make this a reality as part of health care reform.

Discrimination against persons with mental illness is in stark contrast to the scope and prevalence of these illnesses. Mental illness (including substance abuse) affects tens of millions of Americans, knows no geographic boundary, respects no income distinctions, and is unaffected by race, sex, or religion.

- Some 40 million adults in the United States suffer annually from diagnosable mental disorders, including mental illness and alcohol and drug disorders.
- 11 million Americans suffer from "severe" mental illnesses such as schizophrenia, bipolar disorder (manic depression), or major depression.
- 12 million children suffer from some form of mental disorder.
- Maternal alcohol abuse is the leading preventable cause of mental retardation in children.
- One third of the nation's homeless persons suffer from severe mental disorders.
- One-fifth to one-quarter of persons with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all persons with AIDS will develop neuropsychiatric problems.
- Mental illness is a major problem among our nation's elders. At least 50% of elderly nursing residents have a diagnosis of a mental disorder such as major depression. The suicide rate for the elderly is twice that for the general population.
- Alzheimer's disease is the fourth leading cause of death among U.S. adults, afflicting an estimated 4 million elderly Americans who, along with persons with other dementias, occupy more than 50% of the nation's nursing facility beds.
- 30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by 30 percent since 1950.

Mental illness is a serious health care problem in the United States. It should therefore be accorded a high priority in any health care reform plan. The Clinton health care plan -- at least as far as the September 7, 1993, 239 page "Privileged and Confidential" summary -- makes a commendable effort to end discrimination against persons with mental illness. Sadly, we believe that the Clinton plan will not provide non-discriminatory coverage from the outset in 1996. The Administration has made it clear, however, that it plans to phase-in non-discriminatory coverage by 2001.

While we have not yet seen the legislative language (scheduled for release tomorrow), the general outline of the Administration's health care coverage for mental illness includes the following (based on the September 7 draft):

**1996 Mental Health Benefit Coverage Limits
(Clinton Plan, September 7 Draft):**

1. Inpatient Services:

- Defined as: Inpatient hospital, psychiatric units of general hospitals, therapeutic family or group homes or other types of residential treatment centers, community residential treatment and recovery centers for substance abuse, residential detoxification services, crisis residential services, and other residential services. The residential treatment center (at least for children and adolescents) is likely to be separate from the inpatient benefit in the final draft plan.
- Coverage: Initially, 60 days per year and 30 days per spell of illness. While the 30 days "spell of illness" may be waived for patients at serious risk of harming themselves or others, the 60 day annual limit is fixed. *In 1998 the benefit is increased to 90 days per year, with a 30 days per spell sublimit.*
- Other limits: Inpatient hospital care "available only when less restrictive nonresidential or residential" services are "ineffective or inappropriate." Inpatient hospital substance abuse covers "only medical detoxification as required for the management of psychiatric or medical complications associated with withdrawal from alcohol or drugs."

2. Intensive Non-Residential Hospital Alternatives:

- Defined as: Partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home based services, and behavioral aide services.
- Coverage: Initially, 120 days per year.
- Other limits: Provided "only . . . (to avert) the need for, or as an alternative to, treatment in residential or inpatient settings" or to "facilitate the earlier return" of individuals in inpatient or residential programs, or to "restore the functioning of individuals with mental or substance abuse disorders" or to assist individuals in developing the skills they require and to access community supports needed "to achieve their maximum level of functioning within the community."

3. Professional and Outpatient Treatment Services:

- Defined as: Professional services, diagnosis, medical management, substance abuse counseling and relapse prevention, "crisis intervention," "evaluation and assessment," and outpatient psychotherapy.
- Coverage: In general unlimited, except initially 30 visits per year for outpatient psychotherapy.
- Other limits: Substance abuse and relapse counseling "must be provided by licensed or certified substance abuse treatment professionals."

4. Prescription Drugs:

- Defined as: Drugs, biological products, and insulin.
- Coverage: Unlimited.
- Other limits: None, except "reasonable rules for amount to be dispensed and number of refills." Formularies, generic substitution, and drug utilization review are permitted.

2001 Mental Health Benefit Coverage Limits:

By the year 2001, separate duration limits on inpatient, alternative to inpatient, and outpatient psychotherapy services would be eliminated. In effect, the President proposes that all mental health services would be comprehensive and fully integrated, and that coverage of treatment by 2001 for mental illness, including substance abuse, would be non-discriminatory. "Management of benefit" would determine the appropriate service and length of utilization.

Caution, however, is clearly warranted. A careful reading of the September 7, 1993 draft proposal strongly suggests that non-discriminatory coverage will be contingent on cost controls generating sufficient savings to offset any residual funding shortfalls for mental health services. This places non-discriminatory coverage of treatment for mental illness at risk based on the results of managed competition for the entire health delivery system.

Cost Sharing:

As noted, the President's plan envisions three basic types of health care plans: "Low Cost", "High Cost", and "Blended". Mental health cost sharing is defined by the type of plan.

1. 1996 Cost Sharing:

a. "Low cost" (i.e., closed panel HMO) plan:

- No deductible for all services; Annual out-of-pocket limit of \$1,500 per individual/\$3,000 per family

For Mental Health Services:

- Outpatient psychotherapy: \$25 per visit
- Medical management: \$10 per visit
- Prescription drugs: \$5 per prescription
- No other copayments are required.

b. "High cost" plans:

- \$200 deductible for individuals/\$400 for families; Annual out-of-pocket limit of \$1,500 per individual/\$3,000 per family

For Mental Health Services:

- Inpatient care: one-day deductible and 20% coinsurance
- Alternatives to inpatient care: 20% coinsurance
- Medical Management outpatient services: 20% coinsurance
- Prescription drugs: \$250 deductible and 20% coinsurance
- Outpatient psychotherapy: 50% coinsurance

c. "Blended" plans:

These plans will combine the features of both "Low Cost" and "High Cost" plans, depending on whether the provider or service is within the health network or outside it. Thus, for example, inpatient psychiatric services received "inside" the network would require no patient cost sharing, while inpatient services received "outside" the network would require a one-day deductible (in 1996) and 20% coinsurance.

2. 2001 Cost Sharing:

a. "Low Cost" plans:

- 1-12 outpatient psychotherapy visits: \$10 per visit
- 13 + outpatient psychotherapy visits: \$25 per visit

b. "High Cost" plans:

- Inpatient services: Drop 1-day deductible
- Outpatient psychotherapy: 20% coinsurance

c. "Blended" plans:

- Combine features as above (i.e., 20% coinsurance for outpatient psychotherapy if "outside network"; \$10 per visit (for 1-12 visits) for outpatient psychotherapy if "inside network", etc.

Impact of the President's Draft Plan

APA's response to the President's plan is very much on the order of "a glass half full." No other Administration in decades has dedicated so much time and effort to the challenge of health systems reform. Since enactment of the Medicare system some 30 years ago, no other President has attempted to deliver such a detailed plan for health care for Americans.

Here are some of the major positive features of the proposal:

- Coverage: Some 34 million Americans who now lack health insurance will have it.
- Guaranteed Access: All Americans will be guaranteed access to health insurance. "Job lock" will be ended.
- Preexisting Conditions: Health plans will not be able to refuse coverage because of a preexisting health condition.
- Continuum of Mental Health Care: The plan offers broad coverage of a much needed variety of services for treatment of mental illness. Persons requiring psychiatric hospital care will have it. Persons needing non-residential but intensive treatment such as partial hospitalizations will have it. Persons needing outpatient services including psychotherapy will have it. Persons needing medications and medical management of their illness will have it on the same terms and conditions as other medical disorders from day one.

Sadly, while no President in the history of the United States has done more to propose improved access to mental health services, the plan does fall short of APA's objective for our patients of non-discriminatory coverage of treatment of mental illness (including substance abuse).

The President's health care reform package falls short of basic equity for the mentally ill in several respects:

- Coverage: Non-discriminatory coverage of mental illness will be "phased-in" over a 5 year period. In 1996, the plan imposes limits on treatment that are not applied to other illness. For example, outpatient psychotherapy is limited to just 30 visits; inpatient hospital care is limited to 60 days per year.
- Cost Sharing: Patients will pay more out of their own pockets for treatment of mental illness than they will for other covered health services. For example, in the fee-for-service plan, patients will pay 50% coinsurance for outpatient psychotherapy. For patients with severe illness who require hospitalization, the plan will require that they pay a deductible equal to the first day's hospitalization. This is a terrible burden for any patient, let alone someone who is ill enough to require hospitalization.

APA agrees with the President's comments during his national health care address that "we can no longer afford to continue to ignore what is wrong" with our health care system. For the millions of Americans who struggle every day with mental illness and substance abuse, what is wrong is that they are treated differently just because of their diagnosis.

While we are in agreement with Mrs. Clinton's testimony before this Committee about the President's diagnosis of the need for national health care reform coverage of the treatment of mental illness, we respectfully disagree with the way the President has phased-in his prescription for change. Our medical prescription is to call on the Congress to improve the President's plan by treating persons with mental illness with the dignity and compassion they deserve. Congress can best do this by ending any artificial distinctions between the coverage of psychiatric illness and other medical illness.

In addition to determining the scope, duration, level, and type of benefits to be included in health care reform, the Administration, the Congress (and particularly the members of your Subcommittee), will also have to consider a host of related and complicated issues. Let me touch briefly on several of them.

Global Budgets

Under the September 7 "Privileged and Confidential" draft, the national health care budget will be established by the National Health Board. The budget is to be derived from the weighted average premium for the nationally-guaranteed benefits package in regional health alliances. This budget would be translated into a per capita basis (i.e., premium) and would vary regionally. The per capita premium times the number of individuals covered by the Alliance and adjusted for population age, health status and other factors forms the yearly global budget for that Alliance.

If the submitted average premium -- the bids offered by the Accountable Health Plans -- within an Alliance exceeds the premium target, an assessment is imposed on each plan whose bid exceeds the target, and on the providers receiving payment from the plan. Revenues from assessments on plans in excess of the premium target are used to reduce required employer premium contributions. The assessment on the plan is equal to a portion of the percentage amount by which the alliance target is below the bid.

Year-to-year premium increases are limited to the Consumer Price Index (CPI). If however, an Alliance's actual weighted-average premium in a given year exceeds its premium target, then the inflation factor for that Alliance is reduced for the following two years to recover excess spending.

Alliances may utilize various "tools" to meet their premium targets, including: premium negotiation, limiting enrollment in high-cost plans, freezing new enrollment, implementing surcharges on high-cost plans; and setting rates for providers.

While APA recognizes that equitable cost containment must be an essential part of any serious plan to reform the nation's health care system, it is not clear to us how global budgeting is likely to impact the delivery of services to persons with mental illness, and particularly to the most vulnerable populations of those with mental illness, including children and adolescents (who have no insurance of their own), persons with "severe" mental illness, the poor, and the elderly. Cost controls should not translate into little or no services for vulnerable populations or else into shifting persons into an underfunded and often non-existent state system of care.

Graduate Medical Education

The President's draft reform plan -- as would legislation already introduced in the House and Senate -- redirects graduate medical education away from specialties and toward primary care and increased investments in the training of non-physician providers. Within 5 years after the initial phase-in of the reform plan, at least 50 percent of new physicians would be required to enter primary care -- family medicine, general internal medicine and general pediatrics -- rather than in any specific specialty field.

The Secretary of HHS would have the authority to determine the number of training positions in each specialty acting on the recommendations of the National Council on Graduate Medical Education. Furthermore, the Secretary would have the authority to distribute those positions across the U.S. depending on regionally requirements for such specialties. Regional Councils would be established to advise the Secretary on the required regional distribution of physician training slots.

Funding for GME will be pooled from all insurers and Medicare. Medicare will contribute to the Direct Medical Education fund based on the percentage of hospital bed days its patients use (38 percent in 1992). Other payers will contribute through a surcharge on health plan premiums. Funding will be provided directly to training programs approved for residency training position, and non-hospital based training sites will be encouraged.

These efforts will pose severe problems for psychiatric residency and training, presently defined as one of a very few medical shortage specialties by the Council on Graduate Medical Education. The Administration's proposal would only significantly increase this shortage. While psychiatry is not now defined in the statutes as a primary care specialty, psychiatry should not only be defined as such because of its "shortage" status but also because psychiatrists are the "primary care" physicians for the mentally ill. While there will certainly be a significant role for non-physician mental health providers, Congress should recognize that the services of physician and non-physician providers are not directly substitutable in all circumstances. Meat axe proposals to address perceived overspecialization may unintentionally create or exacerbate shortages in needed specialties. APA believes that a more appropriate response to health manpower issues would be to expand opportunities to low-cost cognitive services in shortage, particularly emphasizing underserved geographic areas and public sector service (state hospitals, VA, etc.), rather than simply asserting a fixed policy that one-half of all new physicians should be "primary care" (however defined).

Medicare & Medicaid

As you know, a significant portion of the cost of paying for the new health care system under the President's draft proposal would come from capping and gradually reducing Medicare and Medicaid spending to the Consumer Price Index, with adjustments for population changes. Medicare and Medicaid spending cuts would be substantial: \$238 billion from 1996-2000.

APA is deeply concerned about the ability of these programs to sustain reductions of this magnitude without adversely impacting quality of care. Of particular concern to us is the fact that the President's plan does not as of the September 7 draft propose to end existing discrimination against Medicare patients with a diagnosis of mental illness (such as the 50% coinsurance for outpatient mental health services or the 190 day lifetime limit on treatment in psychiatric hospitals). Since the President's plan would otherwise phase out discriminatory limits on treatment of mental illness in the reformed health system, the distinct possibility is that the Medicare program -- generally among the more comprehensive coverage available today, may actually end up as significantly lesser coverage over time.

Managed Care

Inevitably, a central element in any health care reform plan -- whether the President's, single payer proposals, and so on, will be the increased use of utilization review and other means of managing the delivery of health care services.

APA does not oppose managed care per se. Indeed, based on a series of frustrating exchanges with the Administration's actuaries, we believe that we give more credence to the efficacy of managed care to control medically inappropriate utilization of mental health services than does the Administration's own cost experts. APA does, however, oppose the use of managed care techniques whose sole objective is to reduce costs without regard for the clinical needs of the patient.

APA strongly recommends that the Congress adopt rigorous Federal standards to ensure that the reformed health care system ensures the delivery of the appropriate care in the appropriate setting. Quality of care is a critical element in any reformed system, and we welcome working with the Congress for the adoption of criteria to protect patients from abuse as set forth in the APA model bill on utilization review and managed care.

Trade Offs

There are a whole host of benefit improvements in the mental health area which are worthy of careful consideration by the Congress. These include elimination of cost sharing for low income and indigent patients, special provisions for vulnerable populations such as the severely mentally ill, children and adolescents, and the elderly, expansion of the outpatient psychotherapy visit limit including elimination of discriminatory 50% patient cost sharing, and so on.

The APA is acutely aware of the fact that, because the President's plan does not provide for non-discriminatory coverage of treatment for mental illness from "Day One" that the Congress may find itself under pressure from various groups to trade off one mental health benefit to improve another. APA is adamantly opposed to trade offs within the mental health "box" since this would simply rob one patient population to enrich another, and we hope that you will resist the blandishments by some to pit the mental health community against itself.

Conclusion

Mr. Chairman, in conclusion, we know that timely interventions, including the use of psychotropic medications in conjunction with appropriate psychotherapy, can make an enormous difference to persons with mental illness, enabling them to resume a full and productive life. We also know that these treatments are clinically effective and cost effective. And we know that providing coverage for treatment of mental illness would save the nation nearly \$100 billion in annual indirect costs incurred from our failure to provide access to care today. We thus believe that coverage of treatment for mental illness should be included in whatever health care reform model the Administration ultimately puts forward.

The APA asks simply that psychiatrists and their patients be treated like all other physicians and patients are treated under a reformed health care system. We, and the medical treatments we provide, whether psychotherapy, psychopharmacology or ECT should be subject to the same cost constraints and the same internal reviews as are other physicians and patients. We should be subject to the same outcomes measurements as are imposed on other medical specialties and their patients. These studies will show what we have known all along: mental illnesses are real, can be clearly diagnosed, and can be treated effectively. The time for differential treatment, based on stigma rooted in fear and ignorance, is past.

The APA is heartened by the prospect of reforms to the nation's health care system, and particularly by the prospect that the opportunity for reforming the system as a whole will provide us with an opportunity to end discrimination against persons with mental illness and those who treat them. We hope your Subcommittee and the Congress will seize the opportunity to redress the long-standing and unjustified discrimination against persons with mental illness which have been a feature of our health care system for far too long.

Thank you. I would be pleased to answer any questions.

Mr. KLECZKA [presiding]. We will now hear from Dr. Cohen. This is Dr. Peter Cohen.

STATEMENT OF PETER R. COHEN, M.D., MEDICAL DIRECTOR, DIVISION OF CHILD AND ADOLESCENT SERVICES FOR ADDICTION VICTIM AND MENTAL HEALTH SERVICES, MONTGOMERY COUNTY, MD., ON BEHALF OF AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Dr. PETER COHEN. Mr. Chairman, subcommittee members, the American Academy of Child and Adolescent Psychiatry appreciates this opportunity to testify before your committee. The academy is a national professional association of over 5,300 child analysts and psychiatrists. This medical discipline is concerned with the prevention, diagnosis, and treatment of developmental and psychiatric disorders in children, adolescents and their families.

Whatever system of health care is enacted, children and adolescents with mental illnesses will not be included in the omnibus provisions unless there is provision for their needs. Recognition must be made for the difference in treating and diagnosing adults and children and adolescents.

The following 4 points highlight those differences and offer recommendations to ensure appropriate quality care in any health care reform system.

First, access and nondiscrimination. Children and adolescents have no access to insurance on their own. Provision should be made to include access for all children and adolescents, regardless of the family's status or income level.

Without adequate insurance, without treatment, these youngsters' lives are in jeopardy and are predetermined to have long-term, potentially costly consequences.

Second, range of services. By its nature, treatment for children requires not only involvement of the children and the adolescents and families, as well as collaboration with a network of significant caregivers, such as teachers, social workers, social services, nurses, other mental health care providers and physicians.

These services should include a wide range of treatment options. Among these are preventive interventions, early identification, assessment, and diagnosis, case management, out-patient treatment, partial hospitalization, home based, home intervention services, detoxification, and inpatient treatment.

We have encouraged reimbursement limitations and programs that often seem to favor the most expensive treatments.

Third, cost containment. Encourage the use of the earliest interventions, the level of treatment necessary, treatment and management by appropriately trained physicians in a multidisciplinary treatment team and the most appropriate treatment setting. All of these will involve the children's clinical goals in an economically prudent manner.

As a medical director in a public institution in Montgomery County, our treatment is wide ranging in continuing care for Medicaid and uninsured adolescents and children. It is proof such care can be comprehensive and cost effective within a public sector.

Third, cost containment measures. Managed competition contracts should not be equated to minimum care which in the long

run is too costly. With the use of managed care—there have to be managed care controls and they must be regulated. Case management is essential to mental health care reform, especially for children and adolescents, yet it is rarely included in any kind of plan.

Fourth, graduate medical education. Large areas of the country do not have the capacity to move to a new system because of the lack of providers, and the lack of training of these providers, and especially because of the funding reductions that have occurred. We are a group that is in a shortage situation. This has been determined by Federal studies. There have to be formulas designed to increase the numbers.

The Academy specifically advocates the use of a loan forgiveness program for encouraging medical school students to enter child analysis and psychiatric training, with assurances the monetary support is to be used to treat underserved populations.

Also, the current Medicare program should allow for training that will benefit shortage specialties.

So in summary, reforming the health care system promises to be stimulating and frustrating. It will be worth the effort if universal access can be given to all children and adolescents, if no illness is discriminated against, and if coverage for every treatment is appropriate to the age of the child.

Thank you again for this opportunity to testify.

[The prepared statement follows:]

Testimony submitted by the
American Academy of Child and Adolescent Psychiatry
 October 26, 1993
 before the
U.S. House of Representatives
Committee on Ways and Means

Subject: Health Care System Reform

Introduction

The American Academy of Child and Adolescent Psychiatry appreciates this opportunity to testify before the House Committee on Ways and Means regarding the reforming of the health care system in this country.

I am Peter R. Cohen, M.D., Medical Director of the Division of Child and Adolescent Services for Addiction Victim and Mental Health Services, Montgomery County, Maryland.

American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry is a national, professional association of over 5300 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and a two-year residency training program in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and their families.

**RECOMMENDATIONS FOR UNIVERSAL ACCESS:
 CHILD AND ADOLESCENT MENTAL ILLNESS SERVICES**

Health care reform can mean a comprehensive change to a new benefit and payment system, or it can mean reforming the existing system of public and private insurers. Whether there is a move to a single payor system, a managed competition system, or a combination of proposals, children and adolescents with a mental illness will not be included in omnibus provisions if there is no allowance for their special needs. Legislative and regulatory recognition must be made for the differences in diagnosing and treating adults and children and adolescents.

The following three points highlight those differences and offer recommendations to assure appropriate, quality care under any health care reform system:

Access and Nondiscrimination

- 1) **Children and adolescents have no access to insurance on their own. Provision should be made to include access for all children and adolescents, regardless of their family's status or income level.**

Children and adolescents with emotional disorders now have no assurance their illnesses will be identified, evaluated, diagnosed and treated. A large part of this problem can be traced to youngsters in situations where they have no insurance or are underinsured or who have benefit packages that discriminate against mental illness. Without adequate insurance, without treatment, these youngsters' lives are in immediate jeopardy and are predetermined to have long-term, potentially costly consequences.

No one disputes the estimates that up to eighty percent of children with untreated conduct disorders will have some contact with the criminal justice system. Unfortunately, conduct disorders are too often perceived as just bad conduct. It is not just "acting up," it is a serious emotional disorder that often is denied reimbursement for treatment.

Other serious illnesses such as attention-deficit disorder and Tourette's disorders have had similar problems with reimbursement, often compounding the family and physician frustration and delaying treatment.

The combination of not having access to insurance or not having insurance that will cover mental illnesses is devastating to children and adolescents. Any reform measure approved by Congress must be universal, and it must include a standard benefit package with coverage for treating mental illnesses. To continue to discriminate against people with mental illnesses, either by limiting coverage or by increased copayments only continues the stigma and misunderstanding about these illnesses. For children and adolescents, no treatment or undertreatment means a possible lifetime of unnecessary distress and underproductivity, a costly response in the short or long term.

Range of Services

- 2) **Services provided should include a wide range of treatment options -- including but not limited to preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Treatment for children requires that services involve both the child or adolescent and family, interaction with the education system as well as appropriate collaboration with other significant care givers, teachers, physicians or providers of other needed services.**
 - o Reimbursement for a range of services to treat emotional disorders has increased slowly. Innovations in treatment are inhibited by some reimbursement limitations. The system has tended to favor the most expensive treatment, such as hospitalization and not to include partial hospitalization or therapeutic daycare for the very youngest of those needing treatment. In the case of residential treatment, the shift has been from including to excluding it with no explanation and no addition of other services.
 - o The use of inpatient services, like hospitalization and residential care, should not be discriminated against or unfairly capped because of misperceptions about cost or effectiveness. These are necessary treatments for children and adolescents with severe disorders. Community resources are often limited to inpatient services which has contributed to inappropriate care. A reform proposal must support expansion of community services and adequate reimbursement for providing those services.
 - o Medicaid is designed to provide mental health services (to eligible children and adolescent). Medicaid's mandatory services for children and adolescents with psychiatric illnesses include outpatient hospital services, including partial hospitalization, inpatient hospital and physician services, and services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 1989, Medicaid was amended to require the provision of treatment and follow-up services for problems identified through EPSDT screening even if the state does not normally cover such services through Medicaid.

Most states have not been able to comply with the expanded requirements, primarily for economic reasons that impede the training of screening personnel, the establishment of referral protocols, and the inability to reimburse for professional services at

any more than a minimal level; however, the language of the law reflects a reliable model for both prevention and treatment of serious emotional disorders.

Cost containment

- 3) Incentives should encourage the use of the earliest of interventions, the level of treatment necessary, treatment and management by an appropriately trained physician, and the most appropriate treatment setting possible, all of which would best serve the child's clinical goals in an economically prudent manner.
 - o Managed competition when used for cost containment should not be equated with minimum care. Competition for contracts can lead to mental health benefit packages that discriminate solely because of the stigma of the illnesses involved. Children and adolescents with psychiatric illnesses often require complex diagnostic processes. Comorbidity is high in diagnoses such as conduct disorder or attention deficit disorder and adjustments in the treatment plan may be necessary. Inflexible packages obstruct even standard treatment plans for children and adolescents. Diagnosis of comorbidity requires trained child and adolescent psychiatrists. To miss a diagnosis and leave it untreated, lengthens the treatment and adds to the cost of the illness.
 - o The use of managed care to control medical services must be regulated. The managed care industry's practices vary widely in organizational structure and quality. Reform measures will be compromised if regulation and oversight are not included. Improper utilization review can grossly compromise the treatment and significant psychiatric or physical harm may result. Too often, child and adolescent psychiatrists find that reviewers do not have enough knowledge about treating young patients. Even medical directors, unless trained in child and adolescent psychiatry, make treatment plan review recommendations based on adult practice guidelines.
 - o Case management is essential to mental health care reform. Negotiating with agencies, resources, providers, and specialists is difficult and frustrating, and delays in treatment can result. Case managers must be trained to access a wide range of services and be appropriate in referring to those services.

Graduate Medical Education

A fourth point the Academy stresses for health care system reform relates to the finding that large areas in the country do not have the capacity to move to a new system. One contribution to the gaps in the system is the reduction in federal support for training providers of mental illness treatment. Child and adolescent psychiatry is a clear example of this process.

The current number of fully-trained child and adolescent psychiatrists is estimated at 6,000. The 1980 Graduate Medical Education National Advisory Council (GMENAC) recommendations set the national requirement for child and adolescent psychiatrists in 1990 at 8,000 - 10,000, which was drastically scaled back from original justifiable estimates based on a need for over 30,000. The 1991 updated report on the country's physician workforce needs put the recommendations back to over 30,000 child and adolescent psychiatrists. There is no possibility of reaching this goal anytime in the near future. About 250 child and adolescents psychiatrists complete training each year with only a slightly smaller number retiring or leaving the field each year.

It will take forceful implementation of a wide-range of legislative and regulatory recommendations to increase the numbers of child and adolescent psychiatry residents in the next few years. Health care system reform is the place to start with capacity building for providing affordable, appropriate health care to anyone who is ill. Primary care providers are a shortage specialty that should be encouraged, but other specialties also determined by the government to be in a shortage situation must be included in the formulas designed to increase their numbers.

The Academy specifically advocates the use of a loan forgiveness program for encouraging medical school students to enter child and adolescent psychiatry training. Graduate medical education programs supplying shortage specialists must be supported within any plan to reform the health care system. The loan forgiveness program will attract residents committed to treating children and adolescents with serious emotional disorders. Proposals to attract medical students into shortage specialties should contain assurances that the monetary support is to be used to treat underserved populations and not redirected into subspecialties serving populations not in underserved regions.

The current Medicare program should allow funding of direct and indirect training that will benefit shortage specialties. Any preferential treatment given to residents in primary care, either in stipends or quotas on numbers in training, should be extended to all shortage specialties. It would be appropriate to attach "and shortage specialty physicians" to the references to "primary or generalist physicians" so that both areas of need are included in all the recommendations.

In summary, reforming the health care system promises to be a stimulating, frustrating exercise, but the result will be worth the effort if universal access can be given to all Americans, if no illness is discriminated against, and coverage for every treatment is appropriate to the age of the patient.

Thank you again for this opportunity to testify.

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Chairman STARK. Thank you, Dr. Cohen.
Dr. Javors.

STATEMENT OF JONATHAN R. JAVORS, D.O., MEDICAL DIRECTOR, CENTERS FOR HEALTH EXCELLENCE, SCHERERSVILLE, IND.

Dr. JAVORS. The key question facing our country is do we strive for a health care system or are we content with a sick care system? The sad fact of the matter is in 1991 only 3 percent of the total health care dollars were spent on wellness and prevention. Every American would agree that it is wiser to prevent disease than wait until disease has progressed to the point where human suffering and expense becomes overwhelming.

I believe there are three basic principles that must be implemented for any health care system to be successful. The first must change the system from one of disease treatment to one of disease prevention.

While the Clinton administration plan proposes a basic prevention package, no real incentives are offered. More alarmingly, by changing the Tax Code, any incentives businesses have to continue corporate wellness programs are eliminated.

Through these established programs, companies have consistently shown a 20 percent reduction in health care premiums resulting in an average savings of \$2.66 for every dollar spent on wellness.

Next all Americans must be encouraged to assume responsibility for their health along with financial responsibility for their health care decisions. Americans spend more time, money, and effort on preventive auto maintenance than they do on wellness. The reason is simple.

They have financial responsibility for their cars but not for their health. Managed competition just will not cut it. Managed competition does nothing to encourage individuals to remain healthier; nor empowers financial responsibility for decisionmaking, thereby eliminating the true market competition from the system.

Finally, unnecessary utilization of the system must be discouraged. This can be accomplished by keeping people healthier through wellness programs, decreasing the severity of illness through prevention programs, and giving people the financial responsibility for their own health care decision. The Clinton plan will either increase utilization and cost as experienced by Medicare-mandated DRGs or decrease use by health care rationing, hitting the elderly the hardest.

This is contrary to what Americans expect from the finest health care system in the world. However, there is one program that will advance—has all three principles. This is the medical IRA. When combined with a wellness and prevention riders, the medical savings account addresses all three principles discussed above. Because financial responsibility for all health care decisions are placed in each American's hands and, true, market competition will follow.

Each year unused funds will be placed into a tax-free medical IRA for use after retirement when medical needs may be the greatest. Unnecessary utilization would decrease because of these incen-

tives for healthier living. Other solutions besides managed competition must be explored.

One alternative is the American health care partnership. This would combine the best aspects of the single payer plan with the medical savings account. A true health care partnership should develop between the people, business, and the government.

People need to have control, freedom of choice, and self-responsibility. Unreasoned decisions concerning health care rationing must not be forced. Such a course would be contrary to, as more eloquently spoken by Abraham Lincoln, the better angels of our nature.

Thank you.

[The prepared statement follows:]

Jonathan R. Javors, D.O.
 Medical Director
 Centers For Health Excellence, P.C.

The real question is, do we want a health care system or sick care system? As it is now, we truly have a system which renders care to individuals after they have fallen ill. The sad fact is, that in 1991 only 3% of our health care dollars were spent on prevention programs. It should come, then, as no surprise that businesses, the government, and individuals are being driven to their knees by the weight of the system. Who can argue that it is wiser to prevent diseases than it is to treat disease after they become expensive, both in terms of cost and human suffering.

I believe that for any health care reform system to be successful, three principles must be implemented. First, we must change the system from one of disease treatment to disease prevention. Secondly, individuals must be empowered to assume responsibility for their health, as well as the financial responsibility for health care decisions. Americans spend more time shopping for cars and preventative maintenance than they do for their health care. Thirdly, unnecessary utilization must be decreased in the system.

The important points of the Clinton administration's plan need to be examined. To be fair, the administration's plan would do much to provide access to health care for all Americans. The vast majority of people work. The largest portion of the 35 million Americans lacking health care coverage are people who work for businesses who are unable or are unwilling to provide health care. Mandating that all employers provide health care to their employees will do much to ensure access for all. However, this mandate will either drive some small companies out of business, or force up the price of their goods or services, in which case we will all pay more. This, in addition to new taxes that will be necessary to provide for those not working, or who are covered by Medicare, will certainly hurt our economy.

It is important to also look at how the Clinton plan proposes to deliver this health care. This is through an untested, largely theoretical concept called managed competition. Competition is definitely needed in health care. One of the reasons why cost is out of control is because of the lack of true market competition. The term managed should send shivers up the spine of all Americans who value their democratic heritage. The danger of managed competition is that in the Clinton plan, the entity that would be doing the managing is the government. It is estimated that President Clinton's plan would create 59 new federal programs, expand 20 others, and initiate 70 new federal mandates. This could certainly lead to socialized medicine. This must be scrutinized very carefully, especially when we see the welfare states of Western Europe beginning to dismantle their socialized health care systems because of soaring cost due to lack of competition and unnecessary use of the system.

The competition in health care needs to be managed by the individual and by businesses. Where would Sam Walton and Wal-Mart be today if retail merchandising was managed by the government? Wal-Mart was successful, and consumers were the benefactors because of true market competition. People like the prices, quality, and service. The same needs to be instilled into our health care system.

Now consider the cost. There is only one real way to decrease cost in the health care system, and that is by decreasing utilization. This can be accomplished by keeping people healthier through wellness programs, decreasing the severity of illness through prevention programs, and by health care rationing. The administration's plan only addresses one of these directly, namely prevention. Various prevention programs and health education programs will be covered, but there is no incentive to encourage people to utilize these. As for doing anything else constructive to control cost, we need to look back in history to examine the track record of the government in this aspect. We don't need to look far, only to 1983. In that year, the government instituted DRG's (Diagnostic Related Groups) in an effort to control Medicare spending. We all know what happened. Medicare spending exploded. Why is this? I believe this happened because utilization went up. Doctors, hospitals, and patients just used the system more. There is nothing in the Clinton plan to prevent this from happening again, other than health care rationing, which will hit the elderly the hardest. This is contrary to what Americans expect from the finest health care system in the world.

Right now, there are approximately 45 million Americans over the age of 60 and it is estimated that this number will grow to approximately 70 million by the year 2010. Why is this important? It is known, at this time, that an individual 60 years old will utilize the health care system on an average of three times yearly; at age 70, nine times yearly; and at age 80, twenty-seven times yearly. If these numbers are not decreased, the new system will collapse. Only through decreasing the incidence of sickness by wellness programs, decreasing the severity of sickness by prevention programs, or by health care rationing can these numbers be decreased. Which do we want in our new reformed system?

This brings us to a very grave danger inherent in the Clinton administration's proposed plan. Because of tax code changes, the administration's plan will kill any incentive to promote self-responsibility through corporate wellness and prevention programs now in place. This, without question, should be the single most important component of any proposed health care reform plan; that is, instilling personal and financial responsibility for health care, and individual responsibility for health. The following are some examples of why self-responsibility is so important.

- It has been shown by public health research that the most important determinant of an individual's health is that person's lifestyle. This impacts over 50% of a person's health, significantly more than the health care which that person receives.
- Companies saved, on average, \$2.66 for every one dollar spent on wellness and education programs, through increased productivity, lower medical cost, and decreased absenteeism.
- A report in the July 29th issue of New England Journal of Medicine stated that the best 200 corporate wellness programs cut medical claims by 20%. Made available to all Americans, this by itself could cut \$180 billion dollars from the nation's health care bill.

What is an alternative that should be considered in our new health care system? There is one concept that would encourage self-responsibility and cut administrative cost without reducing care or access to the health care system.

This is called the Medical Savings Account (MSA). There would be two components of the MSA plan. The first would be a basic health care package which could be funded by the employer and employee, if the individual is working, or through tax incentives or tax credits, if the individual is not. (Example, \$3,000 yearly). The second would be purchasing catastrophic insurance to cover any expenses over the \$3,000 basic package spent in any given year. Why would this Medical Savings Account work?

- It is estimated that 90% of all people spend less than \$3,000 annually on their health care. Those people spending less than the base \$3,000 each year would be able to place the remainder into a tax-deductible Medical IRA savings account for use after retirement when their medical needs may be greater. This money could also be invested, which may help other sectors of the economy.
- Administrative cost would decrease due to the fact that each family would be responsible for the first \$3,000. No insurance forms, no government bureaucrat, just write a check and keep the balance in the account current.
- Addition of a wellness and prevention rider would help to change our present health care system from one of disease treatment to disease prevention. A certain amount (10% - 20% as an example) of the base amount would be required to be spent on either wellness or prevention programs. This would help cut \$180 billion dollars yearly from our nation's health care bill.
- As the individual would be responsible for their health care, as well as their health care bill, this would force health care providers to become more competitive, to spend more time on wellness and prevention education, and to utilize outcomes research. Briefly, outcomes research tells both the provider and the patient what treatment works, what doesn't, and at what expected price.

There are other changes that would need to be implemented. One would be the development of community care centers, staffed by primary care physicians and other ancillary personnel, to service areas with limited availability to health care providers. These centers would be involved with patient education programs, prevention, and disease treatment. These would help ease the costly burden in our emergency rooms.

Hospitalization reform also needs to be addressed. A large percentage of in-hospital problems could be treated in step-down units at far less cost. These would be operated by personnel more trained for monitoring patients' care than for treating medical problems. Many people are admitted for observation purposes, for delivery of medications, or for testing procedures.

These step-down units would ensure that patients who truly need the degree of care that only a hospital can provide would be hospitalized at a fraction of the former cost. Regarding hospitals, there could be four main clinical tiers, each with its own administrative procedures, level of treatment, and level of cost:

- Intensive - patients who have severe, life-threatening clinical conditions and require services that are essentially similar to intensive care as provided today.

- Intermediate - those who need extensive monitoring of vital signs along with extensive nursing care.
- Observatory - those who have had elective surgery, those admitted for testing procedures, or those admitted for control of non-life-threatening, specific illnesses. This care would consist of routine vital signs, routine IV fluids, pain control, and medications.
- Maintenance - those who require care similar to that rendered in long-term nursing facilities. One way to decrease the number of people treated in this high-cost fashion is to encourage children to take care of their parents. This could be accomplished through a multifaceted program that includes education, ancillary services, and tax credits for those who care for elderly relatives.

As an example, the community hospital where I practice orthopaedics has a step-down observation unit where treatment is rendered at 25% of the cost for a routine intermediate care bed, at no increased risk to the patient.

Other areas where changes are necessary include, stressing the importance of preventive care during medical schooling, tort reforms, administrative reforms, and health care education classes for our primary and secondary school students. Also included must be insurance reforms to prevent "job lock" and the institution of community-based rating, mandatory seat belt laws, and the proposed "sin tax" on cigarettes and alcohol.

Caution is advised. Make decisions wisely. Implement changes slowly. We must not be forced to make decisions concerning health care rationing which would go against, as so eloquently spoken by Abraham Lincoln, "the better angels of our nature".

Jonathan R. Javors, D.O.
 Medical Director
 Centers For Health Excellence, P.C.

The American Health Care Partnership

MISSION STATEMENT

By forming a true health care partnership between the people and the government, access and peace of mind will be provided for all. In addition, the individual will be empowered to assume control, have freedom of choice, and financial responsibility in the decision-making process for all their health care needs.

METHODS

The American Health Care Partnership (AHCP) will combine the best aspects of the Single-Payor Plan, with the best aspects of the Medical Savings Account (M.S.A.). It is expected that this will provide access to health care for all Americans, while lowering administrative costs. Also, true market competition will be instilled because the control will be with the consumer, in this case the patients and their families, who utilize the system. This will control cost by decreasing unnecessary utilization, and ensure quality through competition. It will allow the government to fulfill its pledge "to promote the general welfare", of which health care certainly is part of. Also, the individual will assume their share of responsibility which is essential in a democratic society.

The AHCP will be controlled by each individual American and administered by the federal government, or those who are deemed appropriate. As of this time, health care revenues come from three sources:

- 20% - Co-payments and out-of-pocket expenses from individuals.
- 40% - Health care premiums from business.
- 40% - Medicare and Medicaid payments from government raised through taxes paid by individuals and business.

Revenues to pay for the AHCP would be generated through a single tax from two sources: (As an example)

- 66% Business
- 34% Individuals

All revenues generated would be placed into the AHCP. All current health related taxes, i.e., health portions of Social Security, are thereby eliminated. Under the AHCP, a single "baseline" amount for health care would be established and 40% of all generated tax revenues would be placed into a general account to cover any individual's health care costs over the baseline. An account for each individual or family would then be established with the remaining 60% of funds. Fifteen hundred dollars per individual and three thousand dollars for a family of four would be examples of two baseline amounts.

Every American would be assigned an AHCP card, corresponding to their Social Security identification number. After every health care use, the health care provider would be reimbursed from the individual's AHCP account. Only when an individual's account is exhausted in any given year would the government become responsible to reimburse the health care provider.

At year-end of every fiscal year, any remaining funds over the baseline in an individual and family account would be placed into a Medical IRA, for investment as an individual may choose. The funds placed into the Medical IRA would then only be available upon retirement or upon eligibility for Social Security. The Medical IRA would be specifically earmarked for health care expenses up to a certain amount. Funds over that could probably be used for non-medical use.

Wellness and prevention must also be addressed. Our health care system must be changed from one of disease treatment to disease prevention and health promotion. This can be accomplished by offering tax breaks to business which provide wellness and health education programs to their employees. Additionally, individuals would be required to spend a certain percentage of their AHCP accounts on prevention, wellness and health education programs.

This brief synopsis is offered as food for thought for implementing the AHCP. Other changes are necessary to give every American what they deserve - the best cost-effective health care system possible.

**TESTIMONY OF JONATHAN R. JAVORS, D.O.
AMERICAN HEALTH CARE PARTNERSHIP**

Of this there can be no doubt, the health care system in our nation is in need of an overhaul. Too many people get sick before they should, too many people have limited access to health care, and for the product, it costs too much. However, we all must realize that the reformed system that evolves will define much more than our health care system. It will define the essence of what form our democratic society will take for decades to come. Don't forget, the decision will affect every single person in our nation, it will affect our right to make choices about a personal matter, and it will affect almost 20% of our economy. We must look beyond the present and consider the future.

Democracy implies a partnership between the government and the people. In a democracy, the government has the responsibility to live up to its pledge as stated in the goals which define it. In the case of our nation, these goals are stated in our Declaration of Independence and Preamble to the Constitution. Certainly, access to health care, along with peace of mind in regards to that health care must become one of the basic rights in our democratic society. Health care has advanced to become a necessity for individuals to completely enjoy the benefits of a modern society, along with the other basic corporal needs such as food, clothing, and shelter. Those who argue this point ignore the reality of modern medicine to influence the quality and quantity of human life and suffering.

However, those living in a democratic society have responsibilities also. These responsibilities extend to the government, to others, and most of all, to ourselves. As dictated by the fact that the government is actually by and for the people as a whole, and the individual singly, each individual's action will have an affect on others. In regards to health care, this implies that the people retain control, freedom of choice, and responsibility for their health, and the health care they receive.

These requirements of both the government and the individual in a democratic society can best be accomplished by a partnership. This would allow the government to live up to its goals, and allow individuals to maintain control. This can work in the health care system.

THE AMERICAN HEALTH CARE PARTNERSHIP

This system will allow health care to be administrated by the government, but the control, choice, and responsibility to be in the hands of the individuals. Important principles that would be adhered to are as follows:

1. Health care coverage would be available for all people of the United States.
2. The government, or those who the government deemed appropriate, would administrate the system.
3. The financial control would be the responsibility of the individual.
4. Complete freedom of choice in utilization of the system would be given to the individual.
5. Unnecessary utilization would diminish because true market competition would be instilled into the health care system.
6. Through wellness and prevention incentives, the health care system would be changed from one of disease treatment to disease prevention.

HOW THE AMERICAN HEALTH CARE PARTNERSHIP WOULD WORK.

There would be a single health care tax. This would cover all the revenues and expenditures for health care in the United States. It would be collected from businesses and individuals. At this time, businesses pay about 65% of the health care expenditures in our system, while individuals pay about 35%. This ratio would stay the same. This would show up on the individual's payroll check under the AHCP Tax. This entire sum of money could be placed into two different accounts, the individual Medical Savings Account, and the umbrella account. Here is how it would work.

INDIVIDUAL MEDICAL SAVINGS ACCOUNT (MSA).

Every single American would have money placed into their MSA. As it is well documented, and actually makes common sense, the older you are, the more you need the health care system, so too, the elderly could have more money placed into their accounts. The following is an example of contributions to individual Medical Savings Accounts.

Age 65 and above	\$2,500.00
50-65	2,000.00
40-50	1,750.00
30-40	1,250.00
20-30	1,000.00
under 20	500.00

Each individual would be issued an AHCP card which has his or her personal MSA account number. Any time that an individual goes to the doctor, or drug store for prescription medications, or hospital or any health care provider, they simply present their card. The account number is entered, and the amount is withdrawn from the account and used to reimburse the health care provider.

Two different situations will then occur. The first is that at the end of the year, an individual will have money left over in their MSA. If this happens, the money left over will automatically be rolled over to the individual's tax-free Medical IRA. This money will be placed in an interest-earning money market account. At the time of retirement, it will be given to the individual for use as he or she deems appropriate. If an individual is already retired, then the money left over in the MSA at the end of the year is given to that individual.

The second situation would occur if the individual has health care costs which exceed the amount in the MSA in that given year. If this happens, then any difference is automatically covered by the umbrella portion of the health care system. This part is administered by the government, but must be used for health care only. The government may manage it themselves, or utilize third party insurance companies such as occurs now in the Medicare system.

If in a given year period, the umbrella portion has funds left in it, then everybody's AHCP tax rate would decrease proportionately for the next year. If in a given year period, the umbrella portion is depleted, then everybody's AHCP tax rate would increase proportionately for the next year.

THE AMERICAN HEALTH CARE PARTNERSHIP - WOULD IT WORK?

All Americans want their health care system to work for them. There are certain goals that must be obtained for the new system to be considered successful. Following are the most important.

HEALTH CARE FOR ALL.

The American Health Care System would ensure that all Americans, for the first time in our history, would have access to health care. Every individual would have a Medical Savings Account, which they personally control.

INDIVIDUAL RESPONSIBILITY, CONTROL, AND CHOICE.

Each individual will have control of the decision-making process in choosing the health care best for them. By wisely shopping for health care, by staying healthy, and by using prevention programs which are encouraged, the potential is present for people to SAVE money each year. And, consistent with our democratic principles, each person will have the freedom to choose what is best for them, not the government.

TRUE MARKET COMPETITION.

Because the individual will be making the financial decisions, this will force health care providers to justify treatment which is advised, explain alternatives more clearly, and prove that their recommendations work. It will force individuals to become more educated, more inquiring, and more involved in their health care. The principles of competition; quality, value, and service, will become the standard in health care.

CUTTING RED TAPE AND THE PAPERWORK QUAGMIRE.

The system will be simple. Present your AHCP card to the health care provider and that service is charged to your account. There will be one standardized form, with standardized service codes. By using electronic filing and computer data processing, the administrative nightmare will end.

DECREASING UNNECESSARY UTILIZATION.

As each individual will have a financial stake in the health care which they receive, you can bet that they will become much better and wiser health care consumers. This will be expected to significantly decrease the unnecessary usage in our present health care system.

RE-ORIENT FROM DISEASE TREATMENT TO DISEASE PREVENTION.

As it stands now, people spend more time on preventative car maintenance than they do on preventative health care. The American Health Care Partnership will change this. It will be stipulated that a certain percentage, as an example, 10%, of each individual's Medical Savings Account must be spent on wellness, prevention, or health education each year. If not, then the left over funds in the MSA will be forfeited.

In addition, businesses which offer wellness, prevention, or health education programs for their employees will be entitled to a tax break on their annual AHCP tax. These incentives will ensure that, we, as a nation, change our present system from one of sick care to one of health care.

These and other advantages of the American Health Care Partnership make it an attractive alternative to the other health care reform plans that are on the table. The United States, as the world leader, and as the guiding light for democracy, must show the world the way to do it right. Not a system copied from other nations, not a system controlled by the government or bureaucrats, but a uniquely American system, with a partnership between the government and the people, working hand-in-hand to improve the quality of our lives in the true spirit of democracy.

The voice of the people is so very important as our elected officials make this monumented decision which will define our society. As such, if you, the reader, believe the American Health Care Partnership has merit and should be considered further, please take time to call or fax your House Representative and United States Senators and propose that he or she explore this plan further.

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Chairman STARK. Thank you.

Dr. Stephen Cohen, did you read in Sunday's New York Times about some oncologists in Tennessee who, marked up cancer drugs by 100 percent and made \$800,000 last year on drug markup alone. Could you consider that sharp business, obscene, or just the normal course of events?

Dr. STEPHEN COHEN. Unconscionable.

Chairman STARK. Not to be left out, these men were in this operation that had one of these medical supply services charging \$529 a day for a intravenous painkiller a competitor was offering for \$367.16 a day. To those folks that we only pay \$30 for a house call, I apologize. We can get it back if you will help us put an end to this type of operation.

Dr. Javors, you had an interesting concept. There was a whole string of things I never heard before. You want to have medical savings accounts which I think will only help the rich. If you are willing to put the lower income people in.

Second, I don't believe that catastrophic insurance does you any good.

Basically, there are damned few procedures other than a routine physical exam that will cost \$10,000 to get into the hospital. If somebody gets sick, they are over the \$3,000 after the first day in the hospital. I have no quarrel if you gave the people \$3,000; but our experience with IRAs is rich people used them, poor people don't. In fact, they borrowed the money to save the taxes. We didn't get anywhere.

But you go on to suggest that we should have a partnership where the government would run the delivery system. Is that what I heard you say?

Dr. JAVORS. Yes.

Chairman STARK. I know people on both sides of those issues, the savings account and the government. Could you elaborate?

Dr. JAVORS. What I foresee happening, obviously this is preliminary thinking and I am not an expert—

Chairman STARK. You are well off.

Dr. JAVORS. The way we could set it up is the government would collect the funds through taxes, as we know now. I believe it is 40 percent of the health care revenues from businesses, 40 percent from the government in the form of taxes by businesses and individuals and 20 percent out of the individual's pockets. The government would collect this, say, as an example, 64 percent from businesses, 34 percent from individuals and put into a pot; 50 percent of it as an example that could be put into overhead and 50 percent could be given back into an individual IRA that everybody would have corresponding to their Social Security number.

Obviously, these sicker people, older people, the elderly would get more money into this IRA whereas the healthier younger people would have less. The money the person did not spend in a 1 year period would go into a medical IRA for them to invest as they so choose but to use later on when they get older in case their expenses go up.

Anything that is spent by that individual on a yearly basis over that baseline, OK, would come out of that 50 percent pot, so to

speaking, that is administered by the government or whoever they deemed appropriate.

Chairman STARK. I worry a little about the person who put their savings in with Executive Life and crooks like Boeskey would steal the money and you would have a bunch of people sitting out there with their savings gone. Absent that, it is a very interesting proposal.

Dr. JAVORS. I believe—you asked the question before, which insurance company gives you the least amount of hassle. If someone walked in your office and opened up their checkbook, their cash, their Visa and MasterCard. This way, if it is on one single—

Chairman STARK. How many do that in your practice?

Dr. JAVORS. Probably about 5 percent.

Chairman STARK. Do they collect when they get home and send the bill to their insurance company?

Dr. JAVORS. No. We give them a super bill. They can, if we would like us to do it, we will bill it for them. If they wish, they can bill their insurance company themselves.

Chairman STARK. Out of that 5 percent, how many do you think have no insurance? They are out there risking it?

Dr. JAVORS. Out of that 5 percent?

Chairman STARK. That pay you cash or write you a check?

Dr. JAVORS. Three percent; in my practice 3 percent are self-payers.

Chairman STARK. Do you all want a shot at the other question?

Dr. Cohen, in your experience of a payment system, without regard necessarily to the fees, but in terms of the hassle factor, do you have one that is less objectionable than other?

Dr. STEPHEN COHEN. Fee for service is least objectionable, least bothersome to the doctor-patient relationship.

Chairman STARK. As far as you know, are the commercial insurance companies all pretty much alike? Do some focus on your consciousness as to one company is much better than another or worse than another?

Dr. STEPHEN COHEN. I think they are all similar. They are all trying to move toward this process of management, invasiveness, calling us on the telephone, having nonexperts interface between the patient and doctor, which I find quite objectionable.

Chairman STARK. So they run the danger of getting just like the others. Dr. Reinstein?

Dr. REINSTEIN. Let me answer that if I may with a very short story.

At 11 p.m. I am called to see a stroke patient having chest pain and shortness of breath. We do an EKG. There are acute changes. If the patient had Medicare, self-pay, anything but managed care, we would move them to coronary care.

Since they have managed care, we have to call the gatekeeper. I call the gatekeeper. I explain what is going on. He says where are you? I say I am in a rehab unit in an acute care hospital.

Why can't you leave the patient on your bed, there are nurses there, you are around, see how things are in the morning and take another EKG. If it is still abnormal, we can move the patient to coronary care then.

We go back and forth for a few minutes.

I finally say, OK, here is what I will do. I will put a note in the chart that in my medical judgment based on my examination of the patient and the EKG, this patient needs to go to coronary care; why don't you get dressed, come in, see the patient, look at the EKG; and under my note, put your note that in your medical judgment, it is fine to leave them on the rehab unit.

There is a long pause. He agrees to let me send the patient to coronary care.

Chairman STARK. You just have to explain some things to some people, don't you?

Dr. REINSTEIN. So it would seem.

Chairman STARK. Dr. Van Camp.

Dr. VAN CAMP. In my experience there is no question that I would agree with these two physicians, that indemnity-type programs have much less hassle. I favor the concept that the patients still are responsible for a percent of their copay. And if they know that they will be paying 5, 10, 20 percent or whatever, they will ask whether procedures are appropriate. And we know that, and we factor that in.

I have always tried to practice on ordering appropriate tests, and I don't—and then I am well able to answer any questions that patients ask. And I welcome them because that is an opportunity to explain why I want this test and how it will fit into their management.

Any time that patients are under HMO-type regulations, there are a lot more hassles. Our judgment is questioned by, usually, people who are not medically well trained.

Chairman STARK. You don't get that hassle from Medicare, if you have Medicare patients, right?

Dr. VAN CAMP. In Medicare there is much less.

Chairman STARK. Dr. Sabshin, my time's out. I just want to run down real quickly.

Dr. SABSHIN. Thank you. We have had an 800 number that has had hundreds of calls from physicians and patients in regard to their experiences. And just on the possibility that you would ask this question, I did check on our experience.

The three best companies for us have been Human Affairs International, it is a carve out from Aetna; U.S. Behavioral Health, which is a carve out from Travelers; and Value Preferred. This is a range that we have from the best experience to terrible catastrophic experience.

And we would be glad to share more of that data with you.

Chairman STARK. It would be interesting to know more of the details. Thank you.

Dr. Cohen.

Dr. PETER COHEN. Fee-for-service indemnity plans.

Chairman STARK. Is Medicare all right?

Dr. PETER COHEN. Tremendous hassle. I do it out of charity. And I believe it—

Chairman STARK. Medicare?

Dr. PETER COHEN. Medicare.

Chairman STARK. More hassle than Blue Cross?

Dr. PETER COHEN. Yes.

Chairman STARK. It is the same company, isn't it?

Dr. PETER COHEN. Yes. But the restrictions, the minutia that you have to pay attention to, sending back of forms, it is a tremendous hassle.

Chairman STARK. All right.

Dr. JAVORS.

Dr. JAVORS. I have—there are 5 full-time physicians that work with me, and we have 15 insurance people. So none of them work very well.

Except, as I said, if they open up their own wallets to pay.

Chairman STARK. You like that one the best.

Dr. JAVORS. Yes, sir.

Chairman STARK. OK, thank you.

Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Let me ask the two psychiatrists: What are your thoughts on how low-income people can get access to mental health care, under the proposed plan of the President or under some new plan, some new system?

Dr. PETER COHEN. How people—

Mr. LEWIS. How will low-income people have access to mental health care?

Dr. PETER COHEN. One, I think is having local community, mental health centers, centers where people can go.

Many times you have to be culturally sensitive. It may be wiser to have services closer to a school or in a building that isn't identified. Furthermore, in having programs accessible, we find out that some people with low income want to solve a problem locally rather than be in distant long-term care facilities. So equal access to care, having access to medical providers, and working along with schools in closer coordination are all good recommendations.

And finally, home-intervention-type services have been found to be very successful in Montgomery County including people in the health system, and allow them to get over their stigma and trust in the care.

Dr. SABSHIN. From my perspective, Mr. Lewis, the best aspect of the President's proposal is its proposal regarding universal access. We live in a system in this country in which poor people have had an abysmal mental health care system, and the opportunity to rectify that is one of the most exciting things in the plan. And a system that will provide universal access is extremely important for this country. I am hopeful that can happen.

Mr. LEWIS. Doctor, what will you suggest to members of the committee that we might do to push mental health further or higher on the agenda? What should we do to make it a greater part of whatever plan we come up with?

Dr. SABSHIN. I hope, sir, that you are willing to take the principle of treating mentally ill people the same as physically ill people. Whatever detail you work out, whatever way to save money, whatever system you evolve, if you accept the principle of equality and nondiscrimination, you will do a great deal for the mentally ill, for the millions of people who need service in this country.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Mr. KLECZKA [presiding]. This panel again has brought with it the specter of a medical IRA; and it seems whenever we have a knotty problem around here, we resolve it with an IRA. We find that first time homebuyers have a problem coming up with a down payment, so the solution to that problem is a first-time homebuyers IRA. And then, when parents have a problem with their education or their children, we have a resolve for that one, too. It is called an educational IRA. And we all know there are retirement IRAs to save for our future. And now we have another IRA for medical needs.

My friends, people don't have that much disposable income to slug away into these IRAs to solve these problems. And I might be dead wrong, but I just don't see any health care reform bill coming out of this Congress next session or next year with this thing called "medical IRAs," because we talk about it for every problem.

Let me focus some attention on the mental health problem and a question or two to Dr. Sabshin. You indicate that mentally ill people should be treated the same way and we should not have arbitrary limits. First of all, the proposal, as we know it today, would probably start out with 60 days inpatient, 30 days outpatient, and then the inpatient would increase over years.

Are you saying we should do away with those types of limits and however we treat other medically ill people, that is, hospital and the like, should be applied to the mentally ill?

Dr. SABSHIN. I would prefer that, sir. And I have indicated, and it is detailed in my written testimony, that a managed care system with adequate utilization review and peer review and adequate guidelines ought to be able to control costs and deal with people equitably. So we say, treat us without arbitrary limits just as you treat people with physical illness.

Mr. KLECZKA. The first criticism of your approach would naturally be the cost. And you are saying the option that you are suggesting would have a positive affect on controlling health costs?

Dr. SABSHIN. Yes, sir, I am saying that.

Mr. KLECZKA. Dr. Cohen, do you want to respond?

Dr. PETER COHEN. Yes. I think one of the difficulties with the present plan, as constructed, is that many of our patients can't afford the copay. And yet you see them going to other physicians and there is no problem with copay.

And so they start to say, well, I won't call you this week; I won't come to you this week; I will wait another week. And that is unfair to people.

Second, of course, has to do with the restrictions in terms of being unable to move to another insurance company because of limitations, preexisting illness limitations.

And, again, I have helped some people become well, but if they go to another insurance company, they often can't get care. So, again, they may have to wait 6 to 18 months to get care.

So I would say that the copay is quite discriminatory.

Mr. KLECZKA. Fine. My time has expired. Good luck on your medical IRA.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I am sorry I am late. Unfortunately we have other ongoing business we have to attend

to. But I couldn't help but hear my colleague's comment about medical IRAs. I was the principal cosponsor in the House of the super IRA, which covered all those other things he was talking about.

And the principal sponsor in the Senate was a Senator from Texas by the name of Bentsen. And he seemed to think it was a pretty good idea at the time as well. Look what happened to him, that is right, my colleague from Michigan says. I don't understand anyone who isn't willing to provide, as an option, a choice in which the individual, if they so desire, based upon their analysis of their lifestyle and their analysis of their medical needs, want to pay for most of the incidental costs of their medical needs with cash and then have a catastrophic backstop safety net package available to them.

I think one of the real fears of those who oppose this concept is that all of a sudden most of the structure that they are advocating to impose upon the Nation perhaps isn't as necessary as some folks advocate.

I don't say that a medical IRA is something that would be available for all. Frankly, there are some who don't manage money well now and it probably would not be a smart thing for them to do.

There are others who would like to just go with a standard program or maybe a mix, typical of the health care plans we have now. But for those who want to, and believe that they can benefit, I don't understand for the life of me why we don't. Especially if we are going to set up a structure. And the Republican plan offers a collection of data through administrative simplification, single form practices, procedures—as virtually everyone advocates—to get a profile in terms of what is offered and the benefits of what is offered so that you can be an informed consumer.

It seems to me that if you want to really get a handle on the cost of medical care, the best thing you can do is provide the information to make the consumer an informed one and then provide a structure in which, if they do a good job, they get rewarded. And in this system, I still don't think there is anything better than the financial reward for prudent behavior.

Any reaction from anyone?

Dr. STEPHEN COHEN. Yes. I would like to comment. I agree, the medical IRA will not be applicable to everyone. But the only way that we are going to contain health care costs in the United States is to have personal responsibility by the patient. The medical IRA is the only way to do it.

To answer an earlier question of Mr. Lewis about what the impact will be on the urban community, those with lower socioeconomic means in the proposed Clinton plan will have a two-tiered system develop. They will absolutely wind up, as the psychiatric patients will, with the least effective care because they are going to get the least expensive program, which will have probably the less willing providers in it. There can be no question that the poor will be underserved, as all people will be by this concept of underutilization for profiteering sake.

Dr. VAN CAMP. I would like to respond as well. I am very impressed that there is no way that we can hold down costs unless we are concerned with prevention. And in this very high-tech world, it seems our choice is either high-tech, high-cost interven-

tions, or low-cost prevention efforts. And we have to look at how can we better prevent disease.

The clinical services packages in the White House proposal highlights immunizations, which are important, mammography, cholesterol testing; but there is no attention toward physician-patient counseling. The physician has a very strong affect on patients in terms of behavioral changes.

And we need to train our physicians to be concerned about physical activities and other lifestyle changes and encourage and implore our patients to adopt those changes.

If we could get people to be physically active, we could do a lot toward reducing strokes, high blood pressure, cholesterol problems, diabetes problems, and coronary heart disease which leads to heart attacks and cardiac arrest. It covers a wide gamut of problems.

And those are the kinds of things that we need to look at. It is really a low-cost approach.

Mr. THOMAS. If we had a solid malpractice provision which gave the doctor-patient relationship, especially on the doctor side, a fairly high comfort level, you could also counsel, in my opinion, a lot more frankly and freely, about that area which consumes enormous amounts of money in a short period of time, and that is the last 6 months of life.

You would be able to counsel, I think, in a more realistic way what some options are and whether or not certain options should be taken. I think that also would be a significant cost saver.

Dr. VAN CAMP. It is going to be important to allow reimbursement for physician-patient interactions and counselings of the type that we both discussed. And in the fee-for—in the managed plans, these have to be made mandatory, an essential part of these plans, so they are not overlooked. It will have long-term savings that will really benefit.

Otherwise, this very worthy goal of health care for everybody is not going to work out financially.

Mr. THOMAS. Dr. Reinstein, I am off my time. But go ahead.

Dr. REINSTEIN. Yes. Thank you. I would just like to answer somewhat in a contrary view in terms of responsibility.

I think part of the problem with the current system, if you work for an employer and they have a strong union, when you pick up your paycheck every week, you look on the paycheck and you have got the Federal tax, you have got State tax, you have got Medicare. And you have either very little or nothing under the health care column.

I think the only way that people will appreciate the costs of health care and the only incentive they are going to have not to spend excess money themselves or go see the doctor every time they burp is if there is a line on there that says health care tax.

If they see that line and that line keeps getting bigger, that will get their attention. Anything short of that, I don't think will.

Mr. THOMAS. Well, I think you will also find that in virtually every plan that is going to be seriously interested, everyone realizes the fallacy of not having a significant copayment. Now we can debate what the significance of that is, but there is no question that it serves as a reinforcement. If you are out something when you make a decision that is not serious or life threatening but is

more of a convenience than anything else, that will modify behavior as well.

It is interesting, the studies I have seen, in which people are quizzed as to how much their health insurance actually costs. They are usually off by about 50 to 100 percent. They have no idea. And that is because the only threshold question that most people ask today, when they go to their physician, is, does my insurance cover it. That is an unacceptable threshold.

Dr. REINSTEIN. If I may, I would also like to take a moment to get back to Mr. Lewis' earlier questions about the question of a two-tiered system.

Without a doubt, managed care, managed competition, are the last great hope of the medical insurance complex. The only way they save money is by having primary care doctors provide care in areas that they do not have training or education or experience to provide that care, with the hope that the problem will just kind of go away.

Mr. KLECZKA. Mr. Levin.

Mr. LEVIN. Thank you. Let me just ask one question relating to mental health benefits. It is my understanding that the proposal or the package that will be formally presented this week will differ from the draft in the area of mental health benefits.

If the two of you could just discuss, and anyone else if they want to add there thoughts, about—what you think the priorities should be. I know that is a sensitive issue, and you don't want to rigidly prioritize, because you feel there should be comprehensiveness. But if you could just discuss for a minute or two the interplay between inpatient, outpatient, number of visits, copays. Because, obviously, in the proposal there are some tradeoffs and they are going to be somewhat shifted in the proposal presented in the next few hours.

Dr. SABSHIN. From my perspective, Mr. Levin, I would not like to advocate tradeoffs at this point, other than to move to a non-discriminatory proposal which was originally proposed by the administration.

At this stage, the priorities within that system seem essentially adequate to me, however. And I think, with the emphasis on the severely mentally ill, it is important to have a system that provides adequate inpatient care and a system that takes care of those people after they leave the hospital.

I am disturbed about the arbitrary limits, on both inpatients and outpatients. I am concerned about the arbitrary limits on the number of outpatient psychotherapy sessions. I don't like the 50-50 copayment. Again, that is a residual of discrimination.

But to the specific of your question, I don't advocate a tradeoff at this point other than move to parity.

Mr. LEVIN. Yes. But you did comment in terms of the primacy of adequate care for the severely mentally ill.

Dr. SABSHIN. Yes.

Mr. LEVIN. OK.

Mr. Cohen.

Dr. PETER COHEN. I would like to comment since I work with both the public and the private sector on what I have been able to see. In the public sector we are able to do a lot and do it within our means and not be under the restrictions of someone who is try-

ing to make a profit and also in terms of mental care such as insurance companies.

I think it can be done in the private sector, too. And the problem in the private sector is that there isn't the incentive to develop the alternative services of care. If you have a case manager and you have someone that is following the patient and knows what is in the patient's best needs, you can then define what level care does that person needs at what time: how much stabilization is needed in the hospital, do we have a foster care home, do we have a partial hospitalization program; do we need to go in for two to four weeks for home intervention services. With these options I think we can keep the costs down. We don't have to make a tradeoff.

In Montgomery County we have these services, and we are finding out we can breathe better. We only have to contract for a little bit of inpatient services.

Mr. LEVIN. OK. Thank you.

Mr. KLECZKA. Any further questions of this panel?

If not, let me thank you all for appearing before us today, and we look forward to your guidance in the months ahead.

Mr. KLECZKA. Let me ask that the fourth panel be seated and prepare for your testimony. Now that we have heard from the physicians, it is the hospitals' turn to give testimony.

We are going to welcome this panel, starting with David Kushner, president of the American Osteopathic Hospital Association; Teri Fontenot, president-elect of the Council of Women and Infant's Specialty Hospitals; Donald Goldberg, chairman of the National Association of Long-Term Hospitals; Robert Trachtenberg, executive director of the National Association of Psychiatric Health Systems; and Kathleen Yosko—am I pronouncing that right?

Ms. YOSKO. Yes.

Mr. KLECZKA. Representing the National Association of Rehabilitation Hospitals.

Let me welcome all of you to the committee today. And we will start out with testimony from Mr. Kushner.

STATEMENT OF DAVID KUSHNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN OSTEOPATHIC HEALTHCARE ASSOCIATION

Mr. KUSHNER. Mr. Chairman and members of the subcommittee, I am David Kushner, president and CEO of a health care organization that, until a few days ago, was known as the American Osteopathic Hospital Association. Last week at our annual convention, we approved a modification to our name to better reflect the changing nature and activities of our membership. We are now called the American Osteopathic Healthcare Association.

We thank you for this opportunity to present our members' views on proposals to reform America's health care system. We are convinced that the system is in urgent need of reform. It is unconscionable that in our wealthy Nation millions of Americans are without adequate health care or lack full access to essential health care services.

We believe, as well, that reform of the system must incorporate a process for controlling health care costs. We recognize that, as

health care providers, we will be on the frontline of the battle to control costs.

I will have several specific comments on reform proposals, but first I would like to take a few moments to talk about osteopathic medicine and its role in our health care system.

Our member hospitals provide a full range of health care services to Americans across the country, often in underserved areas and for populations that are most in need. We are primary care based. However, our staff physicians include specialists as well as general practitioners. Our hospitals are accredited, primarily by the American Osteopathic Association, as well as the Joint Commission on the Accreditation of Health Care Organizations, or by both.

Osteopathic hospitals have long served as sites for community based, postdoctoral training of osteopathic physicians. There are more than 3,300 residency positions in 628 approved osteopathic residency programs for 1993-94.

Osteopathic medicine, now more than a century old, was founded on a holistic approach to health care. It is a parallel form of credentialed medicine. Osteopathic health care emphasizes cost-effective preventive care. In addition to stressing a holistic approach to healing, osteopathic physicians are specially trained in the hands-on, musculoskeletal technique called osteopathic manipulative treatment. This has been proven effective in treating a range of disorders and may result in earlier recovery for many patients. Some 35,000 practicing osteopathic physicians comprise almost 10 percent of all primary care practitioners in the United States. Universities and colleges of osteopathic medicine already surpass the proposed national goal of a 50-50 balance between primary care and specialist graduates. Osteopathic medicine is a choice requested by many patients. According to a recently complete survey by a national physician referral service, the fifth highest-ranking request of people seeking a general practitioner is for an osteopathic physician.

As I mentioned, the American Osteopathic Healthcare Association fully supports health care reform. We have several broad concerns, however.

First, we have grave reservations about the major reductions proposed for Medicare and Medicaid in the name of cost control and for financing coverage for the uninsured. We do not believe that budget cuts of the magnitude proposed by the administration are consistent with maintaining the strength and integrity of Medicare and Medicaid.

Second, we are uneasy about the use of arbitrary measures in determining cost control targets. Keying reimbursement increases to the Consumer Price Index gives no recognition to the reality of costs that may need to be incurred in providing quality health care. We believe cost control targets need to reflect human judgment, rather than arbitrary measures.

Finally, although our hospitals are ready to participate in the market-driven health care environment, we do not believe the plan should be allowed to discriminate among providers on grounds other than quality and cost. Our experience has been that some managed care plans are interested only in hospitals accredited by the Joint Commission and are reluctant even to take the time to

learn that there is a separate widely recognized accreditation process for osteopathic institutions.

Some managed care plans recognize only board certifications approved by the American Board of Medical Specialties and do not take the time to learn that there is a separate, widely recognized, process for board certification through the American Osteopathic Association.

We are concerned also that managed care plans sometimes focus in a community only on the larger institutions, the leaders in market share, and do not provide opportunities for smaller institutions to compete on a level playing field despite their record of high quality and competitive cost.

We believe some provision responding to these competitive concerns about access must be included in any health care reform legislation.

In conclusion, I want to reiterate the American Osteopathic Healthcare Association's support for health care reform. We urge you to continue your efforts to accomplish it despite what we know are many complex issues that will need to be resolved along the way.

We believe that osteopathic health care represents many of the features that health care reform approaches seek: A holistic and preventive approach to health, an emphasis on primary care, accessibility in rural and underserved areas, graduate education of physicians in community hospital settings similar to those in which they will subsequently practice primary care medicine.

The osteopathic profession is an excellent model of efficient health care delivery and medical education. It should be protected and encouraged.

Thank you.

Mr. KLECZKA. Thank you. We will now hear from—is it Fontenot?

Ms. FONTENOT. Fontenot.

Mr. KLECZKA. One more time.

Ms. FONTENOT. Fontenot.

Mr. KLECZKA. Thank you. Forget the T.

STATEMENT OF TERI FONTENOT, PRESIDENT-ELECT, COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS

Ms. FONTENOT. Thank you, Mr. Chairman. I am Teri Fontenot, president-elect of the Council of Women's and Infants' Specialty Hospitals, also known as the WISH Council, and executive vice president of Woman's Hospital, Baton Rouge, La.

The WISH Council represents six of the largest women's hospitals across the United States dedicated to the delivery of quality perinatal care to mothers and their infants.

We are here today to express our hopes for and our concerns about the President's health care reform initiative.

Our hospitals, as well as over 350 other major tertiary perinatal centers in the United States, are the bulwark for the provision of high-risk care to mothers and infants.

We also serve as regional referral centers for perinatal care. It is well documented that much of the decline in infant mortality

over the past 25 years is attributable to the regionalization of perinatal services.

The WISH Council supports efforts to achieve comprehensive health care reform. Indeed, access to care for every woman and infant should be given the highest priority in the Nation's health agenda. We want to ensure that any health care reform plan accommodates and builds upon the regionalized structure for specialized care that has been so significant in improving perinatal care in our country.

We are concerned that, based on the details available to date, the President's reform plan would not embrace this regional structure; rather, under the current proposal, it would appear that health plans would rely on basic obstetrical service and community hospitals for the bulk of their deliveries. This could lead to an erosion of the primary obstetrical care now delivered by large tertiary perinatal centers across the country.

As births in these specialty hospitals decrease, we will mostly be left with high-risk care. The demise of perinatal services in any of these hospitals not only would diminish our patient base but also our ability to deliver high-risk maternal and infant care reasonably. And this loss may be irreparable.

To avoid this, we urge that any reform plan both encourage and build on what is working in the current system, including the regionalized perinatal services network. There are a number of possible ways to achieve this. For example, the plan could build on the concepts in the President's plan of "essential access community providers," "designated specialty providers," and "centers of excellence."

Regardless of the label used for these providers, the key concept is that special attention needs to be paid to assure that cost-effective quality specialty providers are integrated into health care reform in a manner that guarantees their ability to continue to provide the full spectrum of cost efficient quality health care.

Options to ensure the continued viability of these facilities include requiring health plans to contract with designated facilities before pursuing the development of new and duplicative services and requiring regional alliances to directly contract for regionalized and specialized services that would be expensive and inefficient to duplicate in every health plan.

Whatever approach is developed, it will also be critical to ensure that preferred specialty facilities such as the WISH Council hospitals are able to continue to provide preventive, primary, and tertiary services to achieve economies of scale and spread overhead costs.

We have a parallel concern for the physicians associated with our institutions. There has been much discussion on the designation of OB/GYNs as primary care physicians. A significant body of data now has been accumulated supporting the logic of designating OB/GYNs as primary care physicians, as memorialized by H. Res. 234, which currently has 106 cosponsors.

Given the present shortage of primary care providers and the growing concerns about the fragmenting nature of health care services for women, it would seem critical for Federal legislation to designate OB/GYNs as primary care providers.

Impairment of the viability of specialty hospitals and their medical staffs could mean a reversal in the campaign to promote continued improvement of outcomes for mothers and infants. Let us make sure this does not happen.

I would be pleased to answer any of your questions or provide you with additional information.

Thank you.

[The prepared statement follows:]

TESTIMONY ON BEHALF OF THE COUNCIL FOR WOMEN'S AND INFANTS'
SPECIALTY HOSPITALS ON HEALTH CARE REFORM

TO THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

My name is Teri Fontenot. I am President-Elect of the Council on Women's and Infants' Specialty Hospitals (the WISH Council) and the Executive Vice President of Woman's Hospital, Baton Rouge, Louisiana. The WISH Council represents six of the largest women's hospitals across the United States dedicated to the delivery of quality perinatal care to mothers and their infants. These hospitals are: Hutzel/Detroit Medical Center, Detroit, Michigan; Kapiolani Medical Center, Honolulu, Hawaii; Magee-Womens Hospital, Pittsburgh, Pennsylvania; The Women's Hospital of Greensboro, Greensboro, North Carolina; Woman's Hospital, Baton Rouge, Louisiana; and Women & Infants' Hospital, Providence, Rhode Island. We are here today to express our hopes for, and our concerns about, the President's health care reform initiative.

Our hospitals, as well as over 350 other major tertiary perinatal centers in the United States, are the bulwark for the provision of high risk care to mothers and infants. Our hospitals are responsible for providing care to a disproportionate share of the vulnerable populations found in our inner cities. On average, 25-35% of Medicaid or medically indigent mothers deliver in the hospitals in our cities. Significantly, women and infant specialty hospitals also serve as regional referral centers for perinatal care. As such, we assume responsibility not only for mothers that deliver within our walls, but for the universe of mothers and infants across the region. As tertiary referral hospitals, we provide referral and consultation services for physicians and nurses in community and rural hospitals and transport teams for mothers and infants in the region. Many studies have shown that much of the decline in infant mortality over the past 25 years is attributable to the regionalization of perinatal services. Recently, the Committee on Perinatal Health under the sponsorship of the March of Dimes, Birth Defect Foundation has reiterated the need for the regional structure and role of sub-specialty perinatal hospitals. "Regional networks should be structured to ensure that subspecialty care is available to all who need it."

The WISH Council supports efforts to achieve comprehensive health care reform. Universal access to affordable, available and appropriate perinatal care is essential. Indeed, access to care for every woman and infant should be given the highest priority in the nation's health agenda. The WISH Council wants to ensure that any health care reform plan accommodates and builds upon the regionalized structure for specialized care that has been so significant in improving perinatal care in our country. We are concerned that, based on the details available to date, the President's reform plan would not embrace this regional structure that has been successful in reducing infant mortality across the country. More specifically, under the current proposal, it would appear that health plans would rely on basic obstetrical service in community hospitals for the bulk of their deliveries. Under this scenario, we envision an erosion of the primary obstetrical care now delivered by large tertiary perinatal centers across the country. As births in these specialty hospitals decrease, they will mostly be left with high-risk care. The demise of perinatal services in any of these hospitals not only would diminish our patient base, but also our ability to deliver high-risk maternal and infant care to regions. This loss may be irreparable and would result in greater diffusion and duplication of costly high technology care across more basic service hospitals.

To avoid this eventuality, we urge that any reform plan both encourage and build on what is working in the current system, including the regionalized perinatal services network. There are a number of possible approaches to achieve this goal. For example, it could be accomplished by building on the concepts in the President's plan of "essential access community providers," "designated specialty providers," and "centers of excellence." While the precise definitions of these terms are not yet available, the key concept is that special attention needs to be paid to assure that cost-effective quality specialty providers are integrated into health care reform in a systemic manner that guarantees their ability to continue to provide the full spectrum of cost-efficient quality health care. The exact label given these providers is not as important as the need to assure their integration under health care reform.

Options to insure the continued viability of these facilities include: (1) requiring health plans to contract with designated facilities before pursuing the development of new and duplicative services; (2) requiring regional alliances to directly contract for regionalized and specialized services that would be expensive and inefficient to duplicate in every health plan; (3) providing a subsidy for these preferred specialty facilities to help assure that they will be able to continue to compete with community hospitals in a reform environment; and (4) allowing regions the flexibility to establish a comprehensive provider network to care for both healthy and special needs women and infant patients.

Whatever approach is developed, it will also be critical to insure that preferred specialty facilities, such as the WISH Council hospitals, are able to continue to provide preventive, primary and secondary services to achieve economies of scale and spread overhead costs. We look forward to working with you to assure that this can be achieved.

We have a parallel concern for the physicians associated with our institutions. There has been much discussion on the designation of obstetricians/gynecologists as primary care physicians. The majority of the more than 26,000 OB/GYN physicians across the country are considered by most of their patients as their primary care physician. Moreover, one of the most significant preventive health services provided by OB/GYNs is prenatal care and risk assessment before and during pregnancy. A significant body of data has now been accumulated supporting the logic of designating OB/GYNs as primary care physicians, as memorialized by House Resolution 234, which currently has 106 cosponsors. Given the present shortage of primary care providers, and the growing concerns about the fragmented nature of health care services for women, it would seem critical for federal legislation to designate OB/GYNs as primary care providers.

The WISH Council would also like to note the following other potential areas of concern under health care reform.

1. The possible need for revisions and/or clarification to antitrust laws to accommodate the special arrangements that may be necessary to assure the continued viability of regionalized specialty providers such as the WISH facilities;
2. The importance of not eliminating disproportionate share hospital (DSH) payments until such time as a system truly has universal access as well as appropriate payment for the types of services otherwise made available due to DSH funding. Moreover, consideration should be given to an alternative adjustment for providers such as the WISH facilities that continue to serve the higher cost, sicker population; and

3. The need to assure that the protections necessary for hospitals such as WISH facilities not be gutted on a state-by-state basis. While we recognize the importance of providing states the flexibility to establish their own programs to meet unique state needs, the need to assure that the protections necessary for hospitals such as WISH facilities not be gutted on a state-by-state basis. Some mechanism must assure that the concerns we have raised regarding regionalized specialty perinatal networks are protected at the state level as well as at the federal level.

Designating the perinatal high-risk referral hospitals as essential access community providers, designated specialty providers and/or centers of excellence, and designating obstetricians/gynecologists as primary care providers will assure continuation of the progress we have achieved over the past 25 years. Failure to do so under any health care reform plan may mean that women have difficulties in receiving quality primary obstetrical services as well as high-risk perinatal services where appropriate. Impairment of the viability of specialty hospitals and their medical staffs could mean a reversal in the campaign to promote continued improvement of outcome for mothers and infants. Failure to address these concerns could dramatically worsen our infant mortality rate.

We look forward to working with you to assure that health care reform means health improvement for all and particularly for women and infants.

Thank you.

**TESTIMONY ON BEHALF OF THE COUNCIL FOR WOMEN'S AND INFANTS'
SPECIALTY HOSPITALS ON HEALTH CARE REFORM**

**THE HONORABLE DAN ROSTENKOWSKI (D., ILL.). CHAIRMAN
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

**HEARING ON HEALTH CARE COST CONTAINMENT
UNDER H.R. 3600, "THE HEALTH SECURITY ACT"**

My name is Harvey W. Smith. I am President of the Council on Women's and Infants' Specialty Hospitals (the WISH Council) and the Senior Vice President of Kapiolani Health Care System, Honolulu, Hawaii. The WISH Council represents six of the largest women's hospitals across the United States dedicated to the delivery of quality perinatal care to mothers and their infants. These hospitals are: Hutzel/Detroit Medical Center, Detroit, Michigan; Kapiolani Medical Center for Women and Children, Honolulu, Hawaii; Magee-Womens Hospital, Pittsburgh, Pennsylvania; The Women's Hospital of Greensboro, Greensboro, North Carolina; Woman's Hospital, Baton Rouge, Louisiana; and Women & Infants' Hospital, Providence, Rhode Island. In addition, many other tertiary providers of perinatal services, as well as organizations such as the National Association of Children's Hospitals and Related Institutions, Inc. support this initiative. In submitting this testimony, we wish to express our hopes for, and our concerns about the health care reform.

Our hospitals, as well as over 400 other major tertiary perinatal centers in the United States, are the bulwark for the provision of high risk care to mothers and infants. Our hospitals are responsible for providing care to a disproportionate share of the vulnerable populations found in our inner cities. On average, 25-35% of Medicaid or medically indigent mothers deliver in the hospitals in our cities. Significantly, women and infant specialty hospitals also serve as regional referral centers for perinatal care. As such, we assume responsibility not only for mothers that deliver within our walls, but for the universe of mothers and infants across the region. As tertiary referral hospitals, we provide referral and consultation services for physicians and nurses in community and rural hospitals and transport teams for mothers and infants in the region. Many studies have shown that much of the decline in infant mortality over the past 25 years is attributable to the regionalization of perinatal services. Recently, the Committee on Perinatal Health under the sponsorship of the March of Dimes, Birth Defect Foundation has reiterated the need for the regional structure and role of sub-specialty perinatal hospitals. "Regional networks should be structured to ensure that sub-specialty care is available to all who need it."

The WISH Council supports efforts to achieve comprehensive health care reform. Universal access to affordable, available and appropriate perinatal care is essential. Indeed, access to care for every woman and infant should be given the highest priority in the nation's health agenda. The WISH Council wants to ensure that any health care reform plan accommodates and builds upon the regionalized structure for specialized care that has been so significant in improving perinatal care in our country. Any final health reform bill passed by Congress must embrace this regional structure that has been successful in reducing infant mortality across the country. More specifically, under some of the current proposals, it would appear that health plans would rely on basic obstetrical service in community hospitals for the bulk of their deliveries. Under this scenario, we envision an erosion of the primary obstetrical care now delivered by large tertiary perinatal centers across the country. As births in these specialty hospitals decrease, these facilities will mostly be left with high-risk care. Not only will our patient base diminish, but our ability to deliver high-risk maternal and infant care to regions will be threatened because we will not have the financial resources to sustain all specialty services. This loss may be irreparable and would result in greater diffusion and duplication of costly high technology care across more basic service hospitals.

To avoid this eventuality, we urge that any reform plan both encourage and build on what is working in the current system, including the regionalized perinatal services network. There are a number of possible approaches to achieve this goal. For example, it could be accomplished by building on the concepts found in the President's and other plans of "essential access community providers," "designated specialty providers," and "centers of excellence." The definitions of these designations need to assure the continuation of regional perinatal centers as sub-specialty centers providing the full range of services and expertise required for the management of complicated maternity or newborn conditions. These services are essential to assuring good outcomes for mothers and infants. The key concept is that special attention needs to be paid to assure that cost-effective quality specialty providers are integrated into health care reform in a systemic manner that guarantees their ability to continue to provide the full spectrum of cost-efficient quality health care. The exact label given these providers is not as important as the need to assure their integration under health care reform.

Options to insure the continued viability of these facilities include: (1) requiring health plans to contract with designated facilities before pursuing the development of new and duplicative services; (2) requiring regional alliances to directly contract for regionalized and specialized services that would be expensive and inefficient to duplicate in every health plan; (3) providing a subsidy for these preferred specialty facilities to help assure that they will be able to continue to compete with community hospitals in a reform environment; and (4) allowing regions the flexibility to establish a comprehensive provider network to care for both healthy and special needs women and infant patients.

Whatever approach is developed, it will also be critical to insure that preferred specialty facilities, such as the WISH Council hospitals, are able to continue to provide preventive, primary and secondary services to achieve economies of scale and spread overhead costs. We look forward to working with you to assure that this can be achieved.

There has been much discussion on the designation of obstetricians/gynecologists as primary care physicians and we support their designations as such. The majority of the more than 26,000 OB/GYN physicians across the country are considered by most of their patients as their primary care physician. Moreover, one of the most significant preventive health services provided by OB/GYNs is prenatal care and risk assessment before and during pregnancy. A significant body of data has now been accumulated supporting the logic of designating OB/GYNs as primary care physicians, as memorialized by House Resolution 234, which currently has 106 cosponsors. Given the present shortage of primary care providers, and the growing concerns about the fragmented nature of health care services for women, it would seem critical for federal legislation to designate OB/GYNs as primary care providers.

The WISH Council would also like to note the following other potential areas of concern under health care reform.

1. The possible need for revisions and/or clarification to antitrust laws to accommodate the special arrangements that may be necessary to assure the continued viability of regionalized specialty providers such as the WISH facilities;
2. The importance of not eliminating disproportionate share hospital (DSH) payments until such time as a system truly has universal coverage as well as appropriate payment for the types of services otherwise made available due to DSH funding. Moreover, consideration should be given to an alternative adjustment for providers such as the WISH facilities that continue to serve the higher cost, sicker population; and

3. The need to assure that the protections necessary for hospitals such as WISH facilities not be gutted on a state-by-state basis. While we recognize the importance of providing states the flexibility to establish their own programs to meet unique state needs, protections necessary for hospitals such as WISH facilities must not be vulnerable to being gutted on a state-by-state basis. Some mechanism must assure that the concerns we have raised regarding regionalized specialty perinatal networks are protected at the state level as well as at the federal level

Designating the perinatal high-risk referral hospitals as essential access community providers, designated specialty providers and/or centers of excellence, and designating obstetricians/gynecologists as primary care providers will assure continuation of the progress we have achieved over the past 25 years. Failure to do so under any health care reform plan may mean that women have difficulties in receiving quality primary obstetrical services as well as high-risk perinatal services where appropriate. Impairment of the viability of specialty hospitals and their medical staffs could mean a reversal in the campaign to promote continued improvement of outcome for mothers and infants. Failure to address these concerns could dramatically worsen our infant mortality rate.

We look forward to working with you to assure that health care reform means health improvement for all and particularly for women and infants.

Thank you.

Mr. KLECZKA. Thank you. Mr. Goldberg.

STATEMENT OF DONALD H. GOLDBERG, PRESIDENT, NATIONAL ASSOCIATION OF LONG TERM HOSPITALS, AND PRESIDENT, NEW ENGLAND SINAI HOSPITAL, STOUGHTON, MASS.

Mr. GOLDBERG. Mr. Chairman and members of the subcommittee, thank you for allowing me to speak today.

My name is Donald Goldberg. I am president of New England Sinai Hospital in Stoughton, Mass., a member of the board of trustees of the Massachusetts Hospital Association, and president of the National Association of Long Term Hospitals. It is from that perspective that I speak to you today.

The association would ask that you consider three points: First, please understand what a long-term hospital is and its importance to the health care system; second, that we support Chairman Stark's efforts to devise a simpler Medicare for all package; and, third, whatever reform package passes must consider the important role of long-term hospitals.

We feel that President Clinton's reform proposal does not properly reflect an understanding of the role of the long-term hospitals. For example, the President proposes that long-term hospitals be paid as skilled nursing facilities under the Medicare program. This would effectively eliminate the existence of long-term hospitals from the Medicare and Medicaid programs. Long-term hospitals are not SNFs. They are licensed and accredited as hospitals and treat a highly complex medically involved patients.

We treat the patients who are victims of catastrophic illness or injury. And we provide a cost-effective alternative to the general hospital.

A study recognized the high intensity of our patient population. For example, we treat young muscular dystrophy patients who are life dependent on ventilators, cancer patients, AIDS patients, and medically complex patients who also require rehabilitation.

These are the patients for whom the short-lived Medicare Catastrophic Act was enacted, a program which eliminated the day limit for our most disabled patients. Most of our members have a governmental payer mix of around 70 percent. They are evenly split between Medicare and Medicaid. We would almost all qualify for the highest adjustment under the disproportionate share formula if we were subject to the prospective payment system.

I ask that it be clarified that the long-term hospital is part of the hospital service benefit under the reform proposal. We believe that Chairman Stark should be applauded for his recommendations on health care reform. Not only would a Medicare-for-all approach be simpler than the current system, it would combine assuredness of payment with administrative efficiencies.

We recommend that the current Medicare reimbursement principles for PPS exempt, long-term hospitals be applied in a single-payer system, adjusted to take into account the increased population for this payer that would result. This would also guarantee patient access in a uniform system among the States.

Finally, Congress should bear in mind that long-term hospitals can play an important role in the reformed health care system. As

capitation becomes the preferred method of reimbursement, acute care hospitals will face increasing pressure to discharge patients earlier if there is a place for those patients to be discharged to. We believe that we saved money for the Medicare program since the prospective payment system was implemented in 1983, and we believe that our hospitals can continue to save the entire system money in a new, more integrated method of delivering health care.

This concludes my testimony, and I would be happy to answer any questions you may have.

Mr. KLECZKA. Thank you Mr. Goldberg.

[The prepared statement follows:]

National Association of Long Term Hospitals

DIRECTORS

GERRY BRUECKNER
Baylor Center of Restorative Care
Dallas, TX

STANLEY M. FERTEL
Jewish Memorial Hospital
Boston, MA

EARL CILBREATH
Drake Center
Cincinnati, Ohio

DONALD H. GOLDBERG
N. E. Sinai Hospital
& Rehabilitation Center
Stoughton, MA

KATHERINE ILL, M.D.
New Britain Memorial Hospital
New Britain, CT

EDMUND LAWLER
Oak Forest Hospital
Oak Forest, IL

SAMUEL LEIBFELD
Goldwater Memorial Hospital
New York, NY

ARMANDO LOPEZ, Jr.
Lac-Rancho Los Amigos Hospital
Downey, CA

CURTIS MILTON
Maconic Home and Hospital
Wallingford, CT

PHILIP MONTELEPRE
Montelepre Hospital
New Orleans, LA

MARTIN PAUL
Healthwest Bethesda
Lutheran Hospital
St. Paul, MN

MICHAEL ROMAN
Healthwin Hospital
South Bend, IN

NALTH TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES NATIONAL HEALTHCARE REFORM

October 26, 1993

Good morning. My name is Donald Goldberg, the President of the New England Sinai Hospital in Stoughton, Massachusetts. I am a member of the Board of Trustees of the Massachusetts Hospital Association, and I am the President of the National Association of Long Term Hospitals. It is from that perspective that I speak to you today.

The National Association of Long Term Hospitals appreciates the opportunity to testify before your Subcommittee. This is the first time that we have testified before a Committee of Congress, and we believed that with the prospects for healthcare reform facing us, this would be an appropriate opportunity for us to tell you who we are, the types of patients we serve, and the role that we currently play in America's healthcare system and the role that we can play in a reformed system.

We would ask that you consider three main points. First, please understand what a long-term hospital is, and what its importance is to America's healthcare system. Second, we would like you to know that we support Chairman Stark's efforts to devise a simpler, Medicare-for-all package in the reform debate. Third, and finally, whatever reform package passes must consider the important role that long-term hospitals can face in the new healthcare delivery system.

(1) What is a long-term hospital?

Our first point was that we urge you to understand what a long-term hospital is. We believe that the President's healthcare reform package reflects a lack of understanding on this point. For example, the President

proposes that long-term hospitals be paid as skilled nursing facilities under the Medicare program. This would effectively eliminate the existence of long-term hospitals from the Medicare and Medicaid programs. Medicaid reductions would follow due to the so-called "upper limit" regulations.

Another proposal in the President's package limits benefits for "rehabilitation and long-term facilities" to 100 days under the nationally-guaranteed benefits package. Both proposals, taken together, suggest that the President's advisors believe that a long-term hospital is the same thing as a skilled nursing facility.

Please understand that that is not who we are. One reason that we have been exempted from Medicare's prospective payment system is because our patients cannot be grouped in the same manner that patients in acute care hospitals can be grouped into DRGs. Although there is no "average" long-term hospital patient, most of our patients are highly-complex, medically-involved patients with multiple illnesses. We have an average length of stay in excess of

25 days; some of our patients remain with us for years, however, too ill to be returned home, and too unstable to be admitted to a nursing home or skilled nursing facility.

One other thing you should know about us is our great reliance on governmental payors. Most of us have a governmental payor mix of over 70%, evenly split between Medicare and Medicaid. Many of our patients enter our hospitals as Medicare beneficiaries, exhaust Medicare's day limit, and convert to Medicaid. If we were subject to the prospective payment system, and thus eligible for the disproportionate share adjustment, we would qualify for the maximum adjustment available under the law.

(2) Medicare-for-all

Our great reliance on governmental payors suggests that we are not able to cost-shift and rely heavily on the Medicare and Medicaid programs. And that leads me to my next point: our support for Chairman Stark's Medicare-for-all approach to healthcare reform. Not only would a Medicare-for-all approach be drastically simpler than the current system, it would combine assuredness of payment with these administrative efficiencies. Even though Medicare-for-all may not be politically feasible, we can tell you that enactment of the Medicare Catastrophic Coverage Act in 1988 was a great benefit to us and our patients, and its subsequent repeal in 1989 was devastating. Because the vast majority of our patients are over 65, we essentially have experience already with a Medicare-for-all program that other hospitals may not have.

If Medicare were our only payor--as was essentially the case during the one year of MCCA--we could count on assured payments. And, with the appropriate adjustments to our TEFRA limit to take into account more recent costs as well as the increased patient population entitled to Medicare, our hospitals would be able to provide services efficiently and, we believe, in a cost-effective manner. We have, in fact, developed an extremely inexpensive re-basing proposal for long-term hospitals under the Medicare program that would forever address the issue of rebasing and could be easily applied and operated in a reformed healthcare system. We urge your favorable consideration of this proposal--either in the context of healthcare reform, or in the Medicare technical corrections legislation that will soon make its way through Congress. I quote from the October 25th Wall Street Journal where John Rother, Legislative Director of AARP, said that "Our objective is to get Medicare up to the same standard benefit package everyone else (under 65) has". He added, "We recognize we will not get that in year one".

(3) Efficient delivery of services

My final point relates to my earlier comment that the appropriate adjustment to our TEFRA limit would enable us to provide services efficiently and in a cheaper way for America's healthcare system. Let me explain why.

Healthcare reform will cause acute care hospitals to integrate and collaborate to a greater degree than ever before. And, as capitation enters the system as a preferred method of reimbursement, acute care hospitals will face every incentive to discharge patients quickly. Long-term hospitals can respond to both developments.

First, as acute care hospitals integrate and collaborate, they will need to develop alliances with all classes of hospitals. And just as an acute care hospital will find

it beneficial to align with a rehabilitation hospital, for example, for patients who need intensive physical therapy, acute care hospitals will also find it beneficial to align themselves with long-term hospitals treating patients who the Medicare program would consider PPS outliers. Any successful "network" of providers will have to include not only primary care providers and acute care hospitals, but specialty hospitals as well: including long-term hospitals for the patients in which we specialize.

And second, as networks are reimbursed on a capitation basis, an acute care, general hospital will have every incentive to discharge patients more rapidly. And since the patients we treat cannot be cared for in a skilled nursing facility, and certainly can't be discharged to home, we stand ready and willing to take patients discharged from acute care facilities before they become outlier patients.

Over the years, the class of patient our hospitals accepted have changed. Before PPS, there was no incentive for an acute care hospital to discharge its patients because it was paid its costs. But DRGs forced acute care hospitals to consider discharging patients more rapidly. And so, in the mid-1980s, we began to take a more acutely-ill class of patient. That is what the future holds for us: as more and more payors begin to adopt prospectively-determined methods of reimbursement--whether DRGs, or capitation, or other forms--our case mix intensity will increase as well. And if you compare our costs--about \$400 per day--to those of an acute care hospital--on the order of \$800 - \$1,000 per day--it's easy to see why a network would and should include long-term hospitals.

Unfortunately, our hospitals have not been highly visible in Washington in the past, and not everyone has been able to appreciate the important role that we can play in an expanded delivery system. The debate over reforming America's healthcare system provides us, policymakers, and America's acute care hospitals the opportunity to recognize the important contribution we can make.

Thank you for providing me the opportunity to testify today.

Enclosed, for the record, please find NALTH's position on National Health Reform.

National Association of Long Term Hospitals

DIRECTORS

GERRY BRUECKNER
Baylor Center of Restorative Care
Dallas, TX

STANLEY M. FORTIL
Jewish Memorial Hospital
Boston, MA

EARL GILREATH
Drake Center
Cincinnati, Ohio

DONALD H. GOLDNERG
N. E. Sinai Hospital
& Rehabilitation Center
Stoughton, MA

KATHERINE ILL, M.D.
New Britain Memorial Hospital
New Britain, CT

EDMUND LAWLER
Oak Forest Hospital
Oak Forest, IL

SAMUEL LEHRFELD
Coldwater Memorial Hospital
New York, NY

ARMANDO LOPEZ, Jr.
Lac-Rancho Las Amigas Hospital
Downey, CA

CURTIS MILTON
Mosaic Home and Hospital
Willingford, CT

PHILIP MONTFLEURE
Minneapolis Hospital
New Orleans, LA

MARTIN PAUL
Healthcare Fellowship
Lutheran Hospital
St. Paul, MN

MICHAEL ROMAN
Healthwin Hospital
South Bend, IN

TO: NALTH Member Hospitals
FROM: Donald Goldberg, President
RE: Long-term Hospital Under the
American Health Security Act
DATE: October 25, 1993

NALTH has reviewed the Working Group draft of the President's proposal for health reform and some related documents. The Following constitutes important elements of the proposal which affect long-term hospitals. NALTH has, after consulting its legislative committee, established a tentative position which is also set forth below. You are requested to provide NALTH with comments and recommendations within two weeks of receipt of this letter. Please provide your written comment to:

Donald Goldberg
President, NALTH
New England Sinai Hospital
P. O. Box CS-9105
150 York Street
Stoughton, MA 02072

With a copy to:

Edward D. Kalman, Esq.
Behar & Kalman
Six Beacon Street
Boston, MA 02108

Donald Goldberg has been requested to testify before the Health Subcommittee of the Ways and Means Committee and will present views discussed with the NALTH's legislative committee. NALTH believes it will have further opportunities to testify before Congress and to discuss national health reform with members of Congress and committee staff. Your views and participation are welcome.

Significant provisions of the President's proposal which affect long-term hospitals are:

1. Benefits

The scope of covered inpatient hospital services is to be generally defined by a National Health Board. However, inpatient services in a skilled nursing facility or rehabilitation facility are limited to a maximum of 100 days and are only available "after an acute illness or injury as an alternative to continued hospital services".

NALTH Comment: It is unclear whether long-term hospital services are considered extended care services. If long-term hospitals are to be considered within extended care services direct admissions from the community, e.g., from outpatient departments may not be covered; inpatient covered stays may be limited to a 100 day LOS; long-term hospitals would be treated like Medicare SNFs where coverage only exists after e.g., three acute hospital days. It is clear that comprehensive rehabilitation hospital services are subject to the above coverage limitations. Some Medigap policies do not cover non-hospital services or have a reduced benefit for post-hospital "extended care" services. In any event, the prospect of a 100 day limitation on extended care coverage would apply to the Medicaid program for the under 65 year of age population.

2. Medicare Program

States may seek waivers to integrate Medicare beneficiaries into health alliances or a single payor system adopted by a state. Also, PROs are eliminated.

NALTH Comment: While a state must assure the same or better benefits than are now enjoyed by Medicare program beneficiaries, significant questions are presented by potential integration of Medicare benefits with a state system. Services offered by long-term hospitals maybe contracted to other classes of institutional or non-institutional settings within a Health care system or plan. It is unclear whether long-term hospital services would be included within the hospital or limited extended care benefits. Also, elimination of PROs will affect

patient and provider appeal rights when the medical necessity of services are questions.

3. Medicare Savings

A copy of Medicare savings included within the President's proposal are included with this memorandum. The proposal includes a projected \$1.4 billion savings by paying long-term hospitals "at SNF rates".

NALTH Comment: NALTH understands this portion of the proposal may be deleted when the actual legislation is presented to Congress. The proposal would replace current target rates with, at worst, SNF routine cost limits or, at best, routine cost limits constructed specifically for long-term hospitals. Reimbursement at these levels will have a serious effect on long-term hospitals' ability to provide patient care.

4. Medicaid

The Medicaid program will be included within regional alliances. States will remain responsible for payments to alliances made on behalf of AFDC and SSI recipients. States would maintain spending for the "acute-care portion" of health coverage under Medicaid at a level equal to its share of total, national, spending in the year prior to implementation of health care reform.

NALTH Comment: It is unknown whether long-term hospital or rehabilitation hospital services are included within the "acute care portion" for which states must maintain effort. In any event, states would continue to incur a Medicaid liability and would also exercise considerable discretion and regulatory power over health alliances. No explicit provision is made for continuity of services for patients over 65 years of age who convert from Medicare to Medicaid status. NALTH questions whether their patients would be subject to the 100 day limit on extended benefits. NALTH also questions that disruptions in patient care may occur if they are being cared for by a long-term hospital which, at the time of exhaustion of Medicare benefits, is not part of a health system to which a patient belongs or is assigned upon exhausting Medicare benefits.

NALTH POSITION

NALTH requests your consideration and comment on the following position.

For Medicare beneficiaries the hospital day limit on coverage should be repealed. TEFRA target rates should be adjusted in a manner similar to the adjustment which was available under the Catastrophic Coverage Act. NALTH's proposal for conditional rebasing should be adopted. Under NALTH's rebasing proposal, long-term hospitals which meet a 25% disproportionate share test and experience two consecutive years of TEFRA losses would be rebased. The Congressional Budget Office has estimated NALTH's proposal will only cost \$4 million annually. Also, long-term hospitals would be considered essential community providers with whom health alliances must contract.

Please contact us promptly with your views. If your hospital wishes to participate in legislative activities, please indicate the same.

Mr. KLECZKA. We will now hear from Mr. Trachtenberg.

STATEMENT OF ROBERT L. TRACHTENBERG, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

Mr. TRACHTENBERG. Mr. Chairman, members of the subcommittee, I am Bob Trachtenberg. I am the executive director of the National Association of Psychiatric Health Systems, which represents the Nation's specialty psychiatric providers, including hospitals, partial hospitalization programs, and residential treatment centers.

I appreciate this opportunity to testify before you, and I offer my more lengthy statement for the record.

NAPHS strongly supports the need to reform the health care system, and we applaud the commitment President Clinton has demonstrated to focus attention on mental illnesses. The administration's plan has many aspects that we can support. However, there are several issues that need to be further clarified and some that need to be changed or even reshaped. Today I want to outline six principles we believe necessary if mental illnesses are to receive adequate attention and treatment in a reformed health care system.

The first principle is access. Everyone must be covered. There can be no wavering from this basic principle if we are to have a fair and just system.

The second principle is specialization. People must have direct access to organized specialty mental health networks that provide the continuum of care in a community-based setting.

A single entry point for anyone needing mental health care run by a mental health professional, not a primary care gatekeeper physician, allows for more efficient diagnosis and delivery of care.

A recently published study found significant evidence that primary care physicians lack the expertise required to diagnose or treat some chronic conditions, particularly psychiatric conditions and that prepaid physicians are even less able than fee-for-service physicians to detect depression.

One specific option for the delivery of mental health services that we would propose for the subcommittee's consideration is to carve out the mental health piece and allow consumers the option to purchase mental health service separately from other health care services. This would give purchasers more choice and better access to quality mental health care.

The third principle is flexibility. There must be a comprehensive flexible mental health benefit based on medical necessity that provides coverage for the full continuum of mental health services. Treatment is less costly, more effective, and less intrusive if people can have access to the most appropriate, medically necessary level of care.

Too often, arbitrary restrictions in benefit design and lack of access to the full range of services drive people into treatments that are reimbursed but not necessarily the most appropriate treatments. The mental health benefit limits contained in the administration's plan will exacerbate, not improve, this particular problem. This flexibility can be achieved by setting the mental health bene-

fit, as a percentage of the overall benefit, leaving decisions on the care of patients to clinicians and to community needs.

In addition, full flexibility can only occur when the public and private sectors are integrated in a single, seamless system. While this is a goal of the administration, there is no evidence that the States will pool State dollars with private funds to purchase comprehensive mental health care through these alliances.

Whether the comprehensive mental health benefit will be implemented if the States do not pool their funds is unclear to us. We would also caution that integration of services should build on the private health care delivery system rather than on an overburdened, disorganized public system. That would perpetuate a second class status for the mentally ill.

The fourth principle is comprehensiveness. All levels of mental health treatment must be covered, including outpatient, home health care, partial hospitalization, residential treatment, and inpatient care.

The fifth principle is competition. Market forces should be encouraged as the most valid way to deliver cost-effective and affordable care. The system should avoid costly overregulation such as premium caps and highly regulated health alliances. We recognize that there is a need to control costs but believe that rigid global budgets, enforced through the premium caps, are the wrong approach and will lead to lower quality care and rationing. With specialty mental health providers placed at risk for the treatment dollar, we believe that mental health costs can be controlled in a truly competitive environment that would promote increased provider productivity.

The final principle is fair financing. Financing for health care reform should be broadly based and should not disproportionately target Federal programs like the large cuts being proposed for Medicare and Medicaid. Health care affects all society, and financing should not be done at the expense of only some of our citizens.

With that, we look forward to working with the subcommittee and with the administration and would be happy to answer any questions that the committee may have.

Mr. KLECZKA. Thank you.

[The prepared statement follows:]

TESTIMONY OF ROBERT L. TRACHTENBERG NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

Mr. Chairman and members of the subcommittee, my name is Robert L. Trachtenberg. I am the executive director of the National Association of Psychiatric Health Systems (NAPHS). NAPHS represents the nation's specialty psychiatric healthcare organizations--hospitals, residential treatment centers, and partial hospital programs--providing medically directed treatment for people of all ages suffering from mental illnesses. Founded in 1933 as the National Association of Private Psychiatric Hospitals, NAPHS today represents approximately 300 member organizations throughout the United States.

On behalf of NAPHS, I want to thank you for this opportunity to testify before the Ways and Means' Health Subcommittee on our reactions to the mental healthcare component of the administration's proposal for healthcare reform.

NAPHS strongly supports the need to reform the healthcare system, and we are extremely pleased with the commitment President Clinton has made to focus attention on mental illnesses. Millions of Americans suffering from mental illnesses--including many who have no access to coverage--will benefit from the President's recommendations that there be a federally defined mental health benefit, universal coverage, elimination of pre-existing-condition restrictions in insurance plans, and the ability to move between jobs without loss of health coverage.

The administration's plan has many aspects that we can support; however, there are several issues that need to be further clarified and some that need to be reshaped or changed. NAPHS wants to work with the subcommittee, Congress, and the administration to make these necessary changes so that the new healthcare system provides high-quality, cost-effective services to all Americans.

Today, I want to discuss with the subcommittee the basic components that we believe must be part of a healthcare reform plan. These are the same principles that are featured in our association's *Strategy for Change: A Comprehensive Mental Healthcare Reform Proposal*. Before I present our approach to reforming the mental health benefit and delivery system in more detail, I would like to focus on several basic components of the administration's healthcare reform plan as they relate to delivery of mental health services. The administration's ideas--in most cases--mirror six basic principles that NAPHS believes are essential to an improved mental health system.

ANALYSIS OF THE ADMINISTRATION'S PROPOSAL

Universal Coverage

NAPHS strongly supports the administration's plan to guarantee access to health services, and specifically mental health services, for all Americans and legal residents. Under this proposal, more than 60 million Americans who now do not have coverage for mental health care would gain coverage. Moreover, millions of already insured Americans would have access to improved mental health coverage.

Mental Health Benefit

Under the administration's plan, in 1996 coverage for mental health care would include 30 days per episode and 60 days annually of inpatient care with a 20% copayment; 30 outpatient psychotherapy visits per year with a 50% copayment; 120 days per year for intermediate services, such as partial hospitalization, psychiatric rehabilitation, and in-home care, with a 20% copayment; and no limits on visits for medical management, crisis management, evaluation and assessment, and substance abuse counseling.

The plan calls for a public/private integrated, comprehensive benefit with appropriate managed care and no arbitrary limits by the year 2001.

NAPHS recognizes that this benefit package is an improvement over many private-sector mental health benefit packages. However, unlike the benefit for physical illnesses, it continues arbitrary limits, which we believe is not an improvement. As managed care has grown, it has become necessary to have a flexible benefit structure that allows hospitals and clinicians to provide the most clinically appropriate care in the least costly setting. The continuation of a benefit structure based on arbitrary limits would not provide the necessary incentives to move toward a flexible benefit structure.

NAPHS supports a mental health benefit based on medical necessity and delivered along a full continuum of services to allow full treatment flexibility. The NAPHS plan also proposes that, in lieu of arbitrary limits, the mental health benefit be set as a percentage of the overall benefit package. In that way, benefit plans can be tailored to meet the needs of

people with mental illnesses in their respective local markets.

The administration proposes achieving an integrated, comprehensive mental health benefit without arbitrary limits by the year 2001. However, as we understand the administration's plan, states would ideally pool state dollars with private funds to purchase comprehensive mental health care through the alliances. In fact, this may or may not occur. Will a comprehensive mental health benefit be implemented if the states do not pool their funds? We are also concerned about how the public and private sector would be integrated. If, when integrated, the mental health delivery system becomes an extension of the current public system, we may inadvertently be moving toward a second-class system for persons with mental illnesses built on an overburdened, underfunded, understaffed public system. We can do better than that. We must build onto the private system, not expand the public system and place clear expectations on the private system to take all patients.

Restructuring the Delivery System

NAPHS strongly supports the administration's plan to provide strong incentives to move toward integrated, organized delivery systems. However, the administration's plan inadequately addresses access to specialty services such as mental health care. The administration's plan envisions integrated systems that would use a primary care gatekeeper to prevent the use of unnecessary specialty services. Although this is a laudable goal, we are concerned that to keep within the capitated payment amount—these networks will establish barriers to appropriate, medically necessary mental health services. Moreover, it is well documented that general medical practitioners often misdiagnose or mistreat mental illness (Rogers, WH, et al.).

We believe Americans must have specialized mental health networks with a single entry point staffed by a mental health professional for anyone needing mental health care. Specialty mental health networks allow more efficient delivery of care, including evaluation, treatment, monitoring, and follow-up. Mental health specialists are trained to appropriately diagnose and treat mental illnesses in the most appropriate and cost-effective setting.

Other advantages to specialized mental health networks include:

- *availability of more treatment options;
- *improved continuity of care;
- *more effective use of resources through the shift to non-hospital, community-based settings;
- *specialized and standardized systems for measuring services, quality, and outcomes; and
- *predictable annual expenditures for mental health services.

One specific option for the delivery of mental health services that we would propose for the subcommittee's consideration is to "carve out" mental healthcare services and allow consumers the option to purchase them separately from other healthcare services. This delivery method would give purchasers of healthcare greater choice and better access to high-quality, appropriate, cost-effective mental health care.

Competition

Health Alliances

NAPHS supports the formation of health alliances for small businesses so that they can obtain affordable health insurance. However, the administration's requirement that employers of 5,000 or fewer employees purchase health insurance through these alliances will severely limit consumer choice of providers and provider networks. The vast majority of employees in a given state would be forced to purchase health insurance only from health plans certified by the health alliances and within a predetermined price cap set by the alliances. In addition, the strong regulatory role envisioned for the alliances would further limit competition and restrict innovation.

Cost Controls

The administration's proposal would establish a national healthcare budget. To enforce the global budget, a national health board would calculate a per-capita premium target for each alliance. These premium targets would be increased from year to year and gradually (over three years) reduced to the rate of inflation.

NAPHS is very concerned that this method of controlling healthcare expenditures would lead to lower quality of care and the rationing of services. We recognize the need to

control costs, but believe that rigid global budgets enforced through premium caps is the wrong approach.

Financing

The administration's plan would obtain a substantial part of its financing through major cuts in the Medicare and Medicaid programs. These cuts would be on top of the recent reductions in the OBRA '93 legislation. The magnitude of these cuts will clearly affect the quality and level of services provided to our Medicare and Medicaid beneficiaries. NAPHS supports a broad-based financing package in which everyone pays his or her fair share. This approach does not meet this test.

State Flexibility

NAPHS agrees with the administration that healthcare is a local service that should be tailored to community needs. However, the administration's plan, we believe, goes too far by giving states too much flexibility in administering the new healthcare system.

NAPHS believes that giving the states too much flexibility could lead to the creation of 50 different state programs and result in the severe difficulties we see in the Medicaid program. This approach would provide Americans with different levels of quality and access to services according to the state they lived in and would pose a special problem for persons who work and live on the borders of two states.

NAPHS supports federally defining rules for the certification of health plans, rather than ceding this responsibility to each state. We believe there should not only be federally defined rules for health plans in general, but there should be specific federal criteria for the provision of mental health services.

I will now describe how all Americans can have access to high-quality, medically necessary, and affordable mental healthcare.

THE RATIONALE FOR MENTAL HEALTH COVERAGE

Why Mental Health Must Be a Priority

According to the National Institute of Mental Health, almost one-third of American adults will suffer from a diagnosable mental or substance-abuse disorder at some time in their lives. In any given year, mental disorders affect 22% of American adults. This figure refers to all mental disorders and is comparable to rates for physical disorders. For example, respiratory disorders affect 50% of adults, and cardiovascular diseases affect 20%. Severe mental disorders—that is, schizophrenia, manic depressive illness and other severe forms of depression, panic disorder, and obsessive compulsive disorder—affect 2.8% of the adult population, or approximately 5 million people (NIMH Report, 1993). Conservative estimates indicate that about 12% of the nation's children (or nearly 8 million) under the age of 18 are in need of mental health services (U.S. Office of Technology, 1986). At least 3 million of these children are seriously mentally ill (Knitzer, 1982).

The total economic cost of alcohol, drug, and mental disorders is projected to be at least \$273.3 billion, but only one-fourth of this cost is treatment-related. Three-quarters of the economic impact is the result of lost and reduced productivity, death, accidents, fires, law enforcement, and related costs.

Beyond the economic costs are devastating human costs. Suicide is the eighth-leading cause of death among all age groups in the United States—with a rate of 12.5 per 100,000. According to the Mental Health Policy Resource Center, mental illness is the third most limiting—in terms of ability to perform a major daily activity—of all disabling diseases, behind only cancer and stroke. When disability is considered in the context of ability to work, mental illness is the most limiting disease. More than three-quarters (76%) of those whose disability is attributed solely to mental illness are unable to work. And suicide, which frequently is the outcome of an untreated mental illness such as depression, is the eighth-leading cause of death among all age groups in the United States—with a rate of 12.5 per 100,000.

Limitations of the Current System: Coverage and Cost Limits

Although some mental health benefits are available to nearly all employees through existing health plans, mental health coverage is commonly subject to special and substantial limitations in the current healthcare system. Fewer days' coverage or annual or lifetime limits are more likely part of the benefit design for mental illnesses than for any other

illness, and limits are more often arbitrary than based on medical necessity.

Those in need of mental health services who have no insurance (some 37 million Americans) or inadequate insurance must try to access public services with long waiting lists or simply go without care. Because untreated serious psychiatric and emotional disorders become more severe, persons most in need of help often end up in juvenile detention centers, jails, or hospital emergency rooms, where care is most expensive and not necessarily appropriate.

Healthcare reform is essential if we are to have better coordination, delivery, and financing of mental health services. Because we must pay close attention to the costs of this better care, the challenge is maintaining quality while controlling what it costs to provide it. We can meet that challenge.

Many employers and payers fear that mental health costs have skyrocketed and will continue to rise, that they are uncontrollable, and--according to a few viewpoints--they are frivolous. Such fears are not only unfounded, they lead to wrong decisions. Mental health benefits are essential. Without them, the work force is much more prone to reduced productivity, accidents, absenteeism, and even the inability to go to work. Mental health costs can be controlled--and we have extensive evidence of both the cost-containment strategies that work and the effectiveness of psychiatric care.

Mental Health Coverage Is Affordable

Consistently, mental health costs have remained under 10% of average benefit costs. According to a study by Hay/Huggins Company, Inc., there is no evidence that psychiatric-care costs have risen significantly above a constant and manageable 8 percent of total costs (Hay/Huggins Company, Inc., 1992). Even various studies that have reported that higher percentages translate into smaller percentages when examined more closely. For example, the *Report on Expenditure and Utilization Patterns for Mental Illness and Substance Abuse Services* by Richard Frank, Ph.D., and David Salkever, Ph.D., shows that mental health claims were 12.1 percent of the total in 1988. However, according to the Hay/Huggins analysis, the actual *payment* is of a much smaller percentage of the psychiatric-care claims than of other claims, reducing the 12.1 percent to less than 9 percent of total health insurance expenses. Mental health benefit costs have actually risen at a lower rate than those of general medicine.

While general medical benefits grew 10% last year, per-employee costs for mental health and substance abuse benefits rose only 4.6%, according to the *1992 Healthcare Benefits Survey* by A. Foster Higgins & Co (A. Foster Higgins, 1992). As a percentage of total health plan costs, mental health and substance abuse benefits accounted for 7.8% of the total in 1992, down from 8.5% in 1991. Average annual inflation during the past three years for psychiatric and substance abuse benefits has been just more than 9%, less than the 13% average for general medical benefits. These controlled costs are a result of a whole host of cost-containment efforts, some that work well and some that are self-defeating. I will discuss a plan for using the most effective techniques to reform what is currently a non-system into a true United States mental health system.

The Time Is Now to Overcome Discrimination

It's ironic that the movement to curb psychiatric benefits is so active at a time when we know more than ever about how to treat mental illnesses. The science base is expanding, and the treatment of mental illnesses continues to become more and more effective. Actually, treatment success rates are often significantly higher for psychiatric disorders than for general medicine. An example is that treatments for the most severe mental illnesses are often more successful than some cardiovascular treatments. Despite such positive and demonstrable outcomes, discrimination against the mentally ill continues, and it is clearly reflected in benefit design for behavioral healthcare.

Controls That Don't Work

Insurance plans with mental health benefits are traditionally written to cover only inpatient or outpatient treatment settings and none other on the continuum of care. Incentives actually encourage hospitalization--because it's covered--and penalize patients who may benefit from less intensive alternative programs such as partial hospitalization or residential treatment centers (RTCs). Out-of-pocket costs for outpatient care--or no coverage whatsoever for partial hospitalization or RTCs, even though they're less expensive per day than inpatient care--prohibit many people from using these settings. And such inadequate reimbursement discourages providers from offering such alternatives.

Believing they will control costs, many employers put arbitrary limits and caps on mental illness benefits—limits not applied to physical health. Such limits clearly and simply do not work because purely cost-driven plans fail to solve the basic problem: seeing someone through an episode of illness so that he or she returns to work and regains enough mental health to again be a productive community member. Arbitrary insurance decisions—such as to cover inpatient programs, but not partial hospitalization when the latter is as appropriate—may force patients into more restrictive or intense, and certainly more costly, levels of care than they may need.

Added to the problems caused by poor benefit design are the problems of access, for which insurers, providers, and employers all share responsibility. Pre-existing-condition exclusions and employees' inability to take their insurance coverage when they change workplaces locks many into situations detrimental to both the worker and the employer.

Current utilization review decisions may override clinical judgment and contradict what is medically indicated for an individual patient. Who loses in the long-run? Many employees who need treatment cannot get it because not a few HMOs severely limit availability of and access to appropriate and necessary mental health care. A recent RAND study found that the quality of care provided by general medical doctors is "low across the board" for mental health services (Rogers et al, 1993). These general practice physicians referred 10% or fewer of their depressed patients to specialists, counseled half or less for more than three minutes, and prescribed antidepressant drugs only 20% of the time.

Mental health specialists—not primary care, "gatekeeper" physicians—are those with the expertise and training to appropriately diagnose and treat mental illnesses in the most effective and cost-effective manner. A study reported in a 1993 *Health Affairs* supplement found significant evidence that primary care physicians lack the expertise required to diagnose or treat some chronic conditions, particularly psychiatric conditions (Eisenberg, 1992); and Wells found that prepaid physicians are even less able than fee-for-service physicians to detect depression (Wells et al, 1989).

Meaningful mental healthcare reform demands no less than fundamental restructuring of the mental healthcare delivery system. Defining the benefit through limits—even if generous—will repeat the mistakes of the past and be a pyrrhic victory for the mentally ill, at best, if the care continues to be externally managed. Rather, systems of care must develop the capability of managing care in a risk-oriented environment.

PRINCIPLES FOR CHANGE

Financing and Delivery

For Americans to have access to high-quality, cost-effective mental health services, the following changes in the delivery and financing of psychiatric treatment are necessary:

- Establish a mental healthcare benefit, defined as a percentage of the standard benefit package, that covers *medically necessary* psychiatric treatment along a full continuum of services.
- Provide incentives for the development of integrated psychiatric services networks that must be federally qualified to deliver mental health treatment and demonstrate a capacity to manage care.
- Pay federally qualified integrated psychiatric services networks according to risk arrangements most appropriate to the community and population being served.
- Require various cost-sharing requirements—such as higher copayments—for services with greater demand-response so that consumers will have sufficient incentive to avoid overuse of mental health services.
- Require from each integrated psychiatric services network outcome studies that will be made public and, therefore, influence consumer choice.
- Reform health insurance practices, including eliminating preexisting-condition clauses, allowing portability of insurance coverage, and requiring community rating.

The Mental Health Benefit

In a new system, a standard mental healthcare benefit should include all medically necessary psychiatric care delivered through integrated psychiatric services networks. It is

possible to do this--without arbitrary benefit limits--if the mental health benefit is defined as an adequate percentage of the standard benefit package and allocated for medically necessary mental health services. Specific cost-control mechanisms and quality oversights will help ensure that this appropriate care is provided within budgetary limits.

A federally defined benefit package that includes mental health care available to all Americans would eliminate adverse selection, a reason insurers often cite for severely limiting mental health benefits. Some payers argue that general health insurance is purchased because of unknown risks of physical illness, but insurance is selected by the mentally ill because of a known risk. Such adverse selection probably does occur today because the mentally ill understand only too well the discriminatory restrictions found in most healthcare plans. When all Americans have access to coverage under a standard benefit with adequate mental health provisions, the potential for adverse selection disappears.

Also essential to mental healthcare reform is the availability of a full continuum of services. The range of services--already proven and available in the mental health arena--should include early intervention and crisis intervention services; inpatient, outpatient, intensive outpatient, partial hospitalization, and residential treatment programs; medical management; and in-home care. Critics fear that this expansion of covered treatment settings (rather than the traditional inpatient vs. outpatient coverage) is too costly benefit. While there is evidence that utilization does increase when benefits are expanded because there is a backlog of ill people now going without care, many economists agree that "rates of use generally reach a plateau" (Frank et al, 1992). Moreover, providing a single entry point where participating patients would be fully evaluated to determine if care is necessary and at what level would help better manage patients' care.

KEY CHANGES

Healthcare reform changes to the mental health delivery system should include the following:

Easy Access. Diagnostic/referral centers are envisioned as the required entry point into the mental health delivery system. Diagnostic/referral services at these centers will be available 24-hours a day, seven days a week, and the primary function of the centers will be comprehensive evaluation and referral to the most clinically appropriate level of care.

Patients needing mental health services will telephone or visit the diagnostic/referral center that is part of the network they are enrolled in. The center will conduct a rapid, multidisciplinary assessment to determine such patient variables as functional status, severity of the disorder, history, and family and community supports. Based on this evaluation, the patient will be assigned a case manager who will coordinate his or her individual care and placed in the most clinically appropriate setting to meet individual needs.

Comprehensiveness and Coordinated Services. A restructured delivery system will provide incentives for the development of integrated psychiatric services networks. These networks of mental health providers will include inpatient and partial hospitalization programs, residential treatment centers, outpatient clinics, home care and day care services, and independent mental health professionals.

Competition and Choice. In a truly competitive marketplace where access to cost-effective, high-quality mental health services is the goal, it is essential to allow consumers as many options as possible, including choosing a mental health benefit package from competing integrated psychiatric services networks. Whatever plan is adopted for healthcare reform should allow for both competition and choice.

Whether or not the perception that psychiatric treatment costs are out of control and rising faster than the rest of health care is reality, providers must be prepared to assume all or part of the financial risk of care and become more accountable to the payer and the patient. There are numerous mechanisms for establishing risk, including capitation or setting fees based on an episode of treatment or negotiated discounts. The most appropriate arrangement will depend on payer needs, local practices, and the population being covered for care. This requires flexibility in the design of the mental health benefit and opportunity for innovation. Establishing the benefit as a percentage of the benefit package would allow for that necessary flexibility and innovation to address local and payer needs. By assuming the risk, building a capability to manage care, and by fostering

trust between the payers and the provider, the clinician will once again be accountable for treatment decisions, and the need for most forms of external managed care can be eliminated.

Controlling Demand. To help control demand, differential copayments and deductibles for various types of services and populations should be established. Some mental health services have a high level of demand-response (that is, the more the coverage is available, the more the service will be used) and, therefore, the potential to be overused. Cost-sharing requirements would provide incentives to control overuse of services.

Quality Controls. Integrated psychiatric services networks should be federally qualified to deliver mental health services. It is important to clearly define, right from the outset, the basic expectations of any organization that would be part of a network to ensure that the organization is capable of, and likely to deliver, quality care. Requirements for federal qualification would need to include, at least, the following: type and level of staffing, quality assurance and continuous quality improvement, treatment standards, establishment of diagnostic/referral centers as part of the networks, provision of a full continuum of services, profiles of providers based on generally accepted treatment standards, provision of outcome and effectiveness data, case management services, and appeals procedures for consumers.

At-risk arrangements such as HMOs could lead to undertreatment if purchasing alliances and other payers make decisions on price alone, rather than price, service, and value. Therefore, benchmarks that establish reasonable expectations of performance for covered populations are also essential. The performance of some traditional HMOs who have had little experience in treating chronic patients, particularly the mentally ill, is something that should be avoided (Schlesinger and Mechanic, 1993).

Federal qualifications for participating, integrated psychiatric provider networks and an adequate risk-driven payment for mental health treatment will ensure appropriate care within a coordinated system.

Outcomes Strategies. To counter criticism that psychiatry lacks adequate treatment-outcomes data, integrated psychiatric services networks should be required to collect, analyze, and publish outcomes data so that consumers can make informed decisions about value. Public findings will influence consumer choice, as will a standard set of criteria used by everyone to judge outcome and effectiveness of treatment.

Networks should regularly report data about quality, appropriateness of care, mental health status improvement, and patient satisfaction to the community. In addition, providers should be profiled to determine their performance and effectiveness according to generally accepted profiling criteria.

CORPORATE EXPERIENCE

Many employers have found that they can actually do a better job of meeting their employee's mental health needs by designing flexible benefit plans that incorporate elements of the concepts supported by NAPHS.

Digital Equipment Corp. of Maynard, Massachusetts, has publicly supported the notion that mental health benefit limits should not exist. Instead of arbitrary limits, the company recognizes and reimburses for appropriate treatment in a wide continuum of care settings. "If care is managed appropriately, then medically and clinically necessary care will be given to the patient, no matter how many visits that patient might require," according to Susan Goldman, senior mental health and substance abuse consultant for John Hancock Mutual Life Insurance Co., which administers the benefit for Digital. Digital has also required the health maintenance organizations it contracts with to meet standards for access, quality, data, financial stability, and mental health care.

The success of McDonnell Douglas Helicopter Company's managed mental health employee assistance plan comes from a focus on individualized patient-care planning and long-term care management while using a selected-provider network. In their plan, there are no constraints on the type of treatment provided. Eighty percent of charges for approved services are covered, and there is a higher (50 percent) coinsurance if an employee goes outside the preferred provider network. During the first year after this plan was implemented, per capita costs for psychiatric and substance abuse dropped by 34%.

A McDonnell Douglas study projected savings of \$2.1 million over four years.

These are examples of private sector responses that can lead the way to true national reform.

CONCLUSION

NAPHS believes strongly in the need to reform the healthcare system and ensure universal coverage to all Americans while simultaneously controlling costs. We believe the administration's plan is an important step in that direction; however, we also believe that we are just beginning a long and complex process. To be successful we must work to offer all Americans access to high-quality, affordable health care. We are committed to this process of reform, and we offer the resources of our organization to make the needed changes reality.

Thank you, Mr. Chairman, for this opportunity to testify before your subcommittee today. I would be pleased to answer any questions you or other members of the subcommittee may have at this time.

References

- Eisenberg L. "Treating Depression and Anxiety in the Primary Care Setting," *Health Affairs Supplement* Fall 1992; 149-56.
- Frank RG, Goldman HH, McGuire TG. A Modal Mental Health Benefit in Private Health Insurance, *Health Affairs*, Fall 1992; 98-117.
- Hay/Huggins Company, Inc. *Psychiatric Benefits in Employer-provided Healthcare Plans: 1992 Report, August 4, 1992.*
- A. Foster Higgins & Co. 1992 *Healthcare Benefits Survey*, 1992.
- Knitzer, J. *Unclaimed Children*, 1982.
- NIMH. *Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council*, March 1993.
- Rogers WH, Wells KB, et al. "Outcomes for Adult Outpatients with Depression Under Prepaid or Fee-for-Service Financing," *Archives of General Psychiatry*, July 1993; 50:517-525.
- Schlesinger M, Mechanic D. Challenges for Managed Competition from Chronic Illness, *Health Affairs Supplement* 1993; 123-127.
- U.S. Office of Technology Assessment. *Children's Mental Health: Problems and Services*, Duke University Press, 1986.
- Wells K, et al. "Detection of Depressive Disorders for Patients Receiving Prepaid or Fee-for service Care," *Journal of the American Medical Association* 262 (1989); 3298-3302.

Mr. KLECZKA. We will now hear from Ms. Yosko.

STATEMENT OF KATHLEEN C. YOSKO, MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES, AND PRESIDENT, SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK, CHICAGO, ILL.,

Ms. YOSKO. Thank you. I am Kathleen Yosko, president and chief executive officer of Schwab Rehabilitation Hospital and Care Network in Chicago.

Schwab is a freestanding rehabilitation facility with several outpatient sites throughout the city and suburb areas.

I am also a member of the board of directors of the National Association of Rehabilitation Facilities, on whose behalf I am appearing today.

NARF represents 900 members which provide medical, vocational, residential, and employment services to over 4 million people annually, services that help reduce dependence on taxpayer-supported government programs.

We commend the President and the Congress for tackling the difficult health care reform issue. We are pleased with the initial coverage of rehabilitation in the package and offer some refinements to help the President's plan achieve its objectives.

I address these issues more fully in my written testimony, which I ask to be included in the record.

Let me summarize five key areas in which we recommend improvements, based on our current understanding of the plan.

First, in regard to the guaranteed national benefits package, coverage of rehabilitation services should provide a full continuum of care for patients. Therefore, we recommend that the term "hospital" should continue to be defined by reference to the Medicare definition, including a specific reference to rehabilitation hospitals and units; that the term "rehabilitation facility" under the extended care service benefit should be defined as a distinctive level of care so that the full continuum of rehabilitation services is available to all patients; and, finally, that congenital disability should be added to illness and injury as qualifying conditions for services.

Second, in regard to administration and structure and the utilization of managed care plans, our concern is that, given the constraints on financing, there may be a tendency to mandate referrals to the least expensive level of care, which may not ensure the most cost-effective outcomes for persons needing services.

Therefore, we recommend that the standards or parameters for rehabilitation referrals should be set on a national level, preferably in legislation.

The alliances and health plans must be mandated to meet the standards prior to receiving National Health Board approval.

Third, with regard to defining "medical necessity," it is essential that the plan have clear and controlling standards for its determination. These standards cannot be drawn in such a way so that they will result in withholding of higher levels of service. Therefore, we recommend that the new health plan adopt current Medicare inpatient hospital rehabilitation guidelines for medical necessity in relation to rehabilitation.

Fourth, with regard to Medicare and Medicaid, we are concerned about the proposed level of Medicare and Medicaid cuts.

Fifth, regarding prevention initiatives, rehabilitation supports efforts to promote seat belt and helmet laws, smoking cessation, and all efforts to control violence, especially gun violence, because we believe these efforts will reduce total health care costs.

Finally, I want to remind you that a provision of full continuum of rehabilitation services will reduce health care and other governmental expenditures by assisting persons with disabilities to become more independent.

Thank you for your attention.

[The prepared statement and attachments follow:]

**TESTIMONY OF KATHLEEN C. YOSKO
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES**

Mr. Chairman:

I am Kathleen Yosko, President and Chief Executive Officer of Schwab Rehabilitation Hospital and Care Network in Chicago, Illinois. Schwab is a freestanding rehabilitation hospital with numerous outpatient sites throughout the city and suburban areas. We serve over 1200 people annually just at our hospital. I am also a member of the Board of Directors of the National Association of Rehabilitation Facilities, on whose behalf I am appearing today, and of the Medical Rehabilitation Education Fund. NARF is a national organization representing over 900 members who provide medical, vocational, residential, and employment services to over 4 million people annually.

We appreciate the opportunity to testify today before the Subcommittee on issues that have arisen in the health care reform debate. We commend the President and the Congress for tackling this difficult issue. The President's plan takes great steps toward providing health care to numerous people who do not have access, or who have limited access, including persons with disabilities. We are pleased with the initial coverage of rehabilitation and offer some refinements to help the President's plan achieve its objectives. Several of the other plans, but not all, also recognize the importance of rehabilitation services and providers which we commend.

All of us in this room will probably need at least one rehabilitation service sometime in our life. As we sit here today trying to debate the future of health care in America, none of us can contemplate if we will walk out of this room and have a stroke; fall and break our hip; be repairing the house, fall, and injure our spinal cord; or be pleasantly riding our bicycle, hit a stone, fall and hit our head; be shot or stabbed; or have a child born with a congenital problem. We really do not sit around and think about this as our futures.

But for many Americans unwittingly, unexpectedly, and unfortunately these things happen. For example, more than 60 percent of our spinal cord patients have gun injuries. These types of illnesses or injuries require rehabilitation services to help return people to home, to work, to school, and ideally to the active life that they enjoyed. Additionally, for someone born with a congenital or genetic disorder, rehabilitation services can increase their ability to walk, move, write, feed themselves, and therefore attend school, participate in social events and enjoy the kind of life that most of us think is what life is all about.

Rehabilitation services are an integral part of our American health care system. Rehabilitation refers to a variety of services, the goal of which is to minimize physical and cognitive impairments, restore functional ability and return people to their lives. They are cost effective. That is only one reason why they must continue to be a part of any new beginning that we make in the delivery of health care services to Americans. One study shows for each dollar spent on rehabilitation services there is a savings of \$30. The Health Insurance Association of America shows that for each dollar spent there is a savings of \$11 in claims or other expenditures that do not have to be made. People who return to work due to rehabilitation services become tax payers, not tax users. They pay approximately \$700 million a year in federal, state, and local taxes. People who have had a stroke and receive rehabilitation services go home; retain these gains; and continue to be independent. The same study showed that people who do not receive rehabilitation services tend to be rehospitalized and frequently need nursing home care.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. After an evaluation, the team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person had a stroke which impaired the ability to walk, see, swallow and which created weakness on the left side. The goals would include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. If someone had a leg amputated due to diabetes or traumatic injury, the goals would be complete, proper healing of the stump, preparation for fitting with a prosthesis, use of the prosthesis, walking first with an aid such as crutches or a cane and then independently without an aid. All of this is hard work for the person, the therapists and nurses.

Over 80% of the people receiving rehabilitation services return to their homes, work, schools or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

Everyone's ultimate goal is to be as independent as possible and live the life they wish. It is not within our character to want to be dependent due to a physical or a cognitive problem. I can go on about some

of the other attributes of rehabilitation, however, they are summarized in the attachments to my testimony.

NARF has taken a position that any health care reform proposal must:

- * improve access to care for the uninsured and underinsured;
- * maintain and increase the quality of health care;
- * address costs without compromising the above;
- * provide coverage of inpatient and outpatient hospital and community based rehabilitation services;
- * assure that such covered services are delivered in fact to people who need them; and
- * assure people with disabilities have access to the health care professionals and providers they need.

The President's plan makes great strides toward these goals. For example, we support:

- * universal coverage;
- * elimination of preexisting conditions;
- * making coverage available without regard to health status;
- * limits on out of pocket expenditures;
- * coverage of inpatient and outpatient rehabilitation services; and
- * prevention initiatives.

Let me now turn to our specific concerns and recommendations for refinements to the plan based on the September 7 draft. We will have more specific recommendations for the Subcommittee once we have seen the final plan.

1. Coverage Mandate

The President has proposed universal coverage, which we support. Universal coverage brings financial access to health care services to some 35-40 million people who are now uninsured and thus expands the potential for delivery of rehabilitation services. The draft states that IRS definitions will be used in defining who is and is not an employee.

Recommendations:

- a. NARF supports the use of the current IRS definitions of employee; however, once we have seen the final plan, we will have some recommendations to offer regarding the definition of employee. The objective of these recommendations will be to clarify who are the employees and who are the clients of a rehabilitation facility.
- b. NARF supports elimination of preexisting conditions clauses, requiring coverage without regard to health status, and increased portability of insurance.

2. Guaranteed National Benefits Package

The plan proposes coverage of both inpatient and outpatient rehabilitation which NARF fully supports. Coverage of such services should provide a full continuum of care for patients needing rehabilitation services. Ideally, they will be delivered as quickly and efficiently as possible to the major benefit and prompt recovery of a rehabilitation patient. The following recommendations are intended to assure that the full continuum of care is available to patients and in support of achieving the President's objectives.

a. Inpatient Hospital Rehabilitation Services

A hospital is defined by reference to the Medicare act which includes "an institution...primarily engaged in providing... rehabilitation services for the rehabilitation of injured, disabled, or sick persons."

Recommendations:

NARF supports defining the term hospital by reference to the definition in the Medicare act. There should be a specific reference to rehabilitation hospitals and units in the final report to clarify further that they are part of the hospital service benefit.

b. Extended Care Services

The plan proposes 100 days of extended care services per year to be provided in a skilled nursing or rehabilitation facility. Such coverage is available "only after an acute illness or injury as an alternative to continued hospitalization."

Recommendations:

NARF recommends that the term rehabilitation facility be defined so that the full continuum of care is available for rehabilitation patients. Once we have seen the final plan, we will propose a specific definition to achieve this objective.

c. Outpatient Services

The plan covers hospital outpatient rehabilitation services as well as physical therapy, occupational and speech therapy to restore functional capacity or to minimize limitations on physical and cognitive functions as a result of illness or injury. Again we commend the President for his recognition of these critical outpatient services that focus on community based care and care in the home for rehabilitation patients. However, we suggest the following recommendations in order to further achieve these objectives.

Recommendations:

- 1) The list of services under outpatient services should be expanded to include psychology and social services and rehabilitation nursing services when provided by a Comprehensive Outpatient Rehabilitation Facilities as defined under section 1861(cc) of the Social Security Act.
- 2) Cognitive therapy, audiology and hearing tests should also be added.
- 3) The 60 day evaluation period must be interpreted only as an evaluation period as is the current practice under Medicare with which the field is familiar, and not be interpreted as a limit.
- 4) Congenital disabilities should be added to illness and injury as qualifying conditions for services.
- 5) The limitations on coverage of prosthetic and orthotic devices, including replacements should be removed. All prosthetic and orthotic devices are custom devices. Replacements are needed due to growth and change as well as normal wear and tear.

3. Administration and Structure: the National Health Board, State Role, Alliances and Plans

The health care reform plan proposes a major change in the structure and delivery of health care services. Essential to this structure is the creation of a national health board, regional and corporate alliances and accountable health plans. States play a major role in creating alliances and certifying plans. The plan encourages the use of health maintenance organizations and other types of managed care plans. Attachment A highlights some of the problems that rehabilitation has experienced with managed care plans. Our experience has not been encouraging. Given the constraints on financing, there may be a natural tendency to refer to the least expensive level of care which may not insure the most effective outcomes for persons needing services. It is critical to guard against this unfortunate situation which has already resulted in people ending up in inappropriate settings that do not meet their individualized needs. Therefore, mechanisms must be in place to assure the referral for, and delivery in fact, of covered rehabilitation services. The individual, social and economic price of not doing so, thereby leaving people as dependents, is morally and financial repugnant to our nation and its values.

a. The National Health Board

The Board will have considerable power. Membership will be limited to 7 people. Once the law is passed, the Board will have tremendous power to set, and later change, the benefits package and the budgets, establish standards for state plans, as well as design the quality management system.

Recommendations:

- 1) The membership of the Board must include a provider of rehabilitation services, a consumer of rehabilitation services and a person with disabilities.
- 2) In order to assure that people who need covered rehabilitation services actually receive them, the National Health Board must set standards/criteria or parameters which the states must assure they will meet, and that any alliance or health plan will meet, prior to the Board approving any state plan and prior to any state plan certifying any accountable health plans or designating an alliance. Some initial standards are outlined in Attachment B. These same standards must apply to corporate alliances, which the Department of Labor will administer.

b. State Responsibilities

States will establish regional health alliances. They will assure that each alliance establishes a risk adjustment mechanism for differences in patient populations related to age, gender, family size and health status. They may provide incentives to serve disadvantaged groups, such as transportation services. States will also regulate the health plans. The states will define requirements related to levels and geographic distribution of services to ensure access. States may establish requirements for plans to assure access, including requirements to reimburse or contract with designated specialty providers and centers of excellence.

Recommendations:

- 1) States must assure that the alliances and plans adhere to the standards, criteria and parameters in Attachment B.
- 2) Rehabilitation providers must be eligible to become specialty providers and centers of excellence.
- 3) Rehabilitation providers should participate with states on all advisory and planning committees.

c. Alliances

Alliances designated by the state will operate under a board of employers, employees, the self-employed and consumers. There will also be a Provider Advisory Board made up of health care professionals. Alliances must also have an ombudsman to help consumers in dealing with the plans and the alliance. Alliances will publish quality performance reports on each plan. Alliances must offer at least one fee for service (FFS) plan with some limits and exceptions. Alliances may adopt a fee schedule to use in FFS plans which will be negotiated with providers. Managed care plans are encouraged.

Recommendations:

- 1) FFS plans must be allowed to be offered by alliances.
- 2) Alliances must comply with the criteria/standards recommended in Attachment B and assure that the health plans do so as well.
- 3) The Provider Advisory Board must include rehabilitation providers, as well as the professional disciplines.
- 4) There should be an annual open enrollment period to allow individuals to switch plans if they find their current plan unsuitable. People needing rehabilitation services and persons with disabilities need

this flexibility, especially if their plan is not responsive to their needs.

5) Outcomes information should be distributed to employees and individuals. Rehabilitation's focus is on improved motor and cognitive function, a measurable outcome. The information each alliance must report should include outcome information on improvement in function as well as including vocational and living status. Rehabilitation providers should have an opportunity to work with each local health alliance in developing the outcomes information to be requested.

d. Health Plans

All persons in an alliance would enroll in a health plan. Community rating would be used to determine premium costs, with a risk adjustment determined by a formula developed by the NHB. Reinsurance would be allowed. Plans would provide information on costs, procedures to control utilization and expenditures, and benefits, risks and costs of various procedures. Grievance procedures must be established. Except in FFS plans, the plans can limit the number and type of providers. They will require referrals for treatment by specialist physicians or health institutions; and establish different rates for out of plan providers. Providers in the plan will compose the advisory board. Plans may pay on a per capita basis and have protocols for managing high cost patients.

Plans would be at risk for providing the benefits package and would have incentives to provide them at the lowest possible cost. This could well result in inadequate treatment, through failure to refer for rehabilitation, arbitrarily limiting the scope, duration or frequency of treatment and/or selecting a site that is inappropriate for the patient's needs.

Recommendations:

- 1) To assure referral and delivery of necessary rehabilitation services, plans must meet certain standards and criteria. Several of these are recommended in Attachment B.
- 2) There must be an adequate number and variety of rehabilitation providers allowed to contract with each plan to assure that a full continuum of care is available to plan enrollees.
- 3) We remain concerned about how rehabilitation and other services will be delivered if plans run out of funds.

4. Medical Necessity

Under the plan, health alliances and plans will have to administer the coverage determined by law utilizing premium income. Since the amount of money will be finite and the benefit structure fixed, the only variables available for cutting costs are rates of payment to providers of services and the extent of care provided. Under these circumstances there is a danger that specialty services such as rehabilitation will be restricted through determinations they are not medically necessary. Accordingly, it is essential that the plan contain clear and controlling standards for determinations of medical necessity.

NARF's experience with the interpretation of medically necessary services is varied. NARF is concerned that such a standard could be used not to the patient's best interest, but to withhold services. This is an experience that several facilities have had under current managed care programs, both Medicare and non-Medicare. This practice should not be continued as we make a new beginning in the delivery of health care.

Recommendations:

We will deliver a more specific recommendation once we see the final plan. However the current Medicare inpatient hospital rehabilitation guidelines found in the Medicare Intermediary Manual at Section 3101.11 have been used to determine the need for hospital rehabilitation services for over 15 years, and therefore are well known and tested.

5. Supplemental Health Insurance

People could buy insurance for what is not covered in the guaranteed benefit package, other than for long term care and some other specific types of insurance. One of the benefits that could be included in a supplemental package is long-term rehabilitation services. Such insurance would be available to all plan participants at the same price. Such services are available only to those who can afford to purchase it. This may be a severe limitation for persons with disabilities. Depending on how long term rehabilitation is defined, the standards for such plans may place limits on the guaranteed benefit package, and therefore the availability of rehabilitation and needed services such as DME and prosthetics and orthotics.

If there is a supplemental insurance program, it should supplement and interface with the guaranteed national benefits package to assure that care for those who can afford to purchase it is seamless.

Recommendations:

NARF recommends that the definition of long term rehab for this purpose mean rehabilitation that would be provided after a stay in a rehabilitation hospital, after receipt of the 100 days of services under the extended care benefit and/or after receipt of the covered 60 days outpatient and/or home health services. These should be allowed to be provided first before requiring anyone to purchase supplemental insurance.

6. Medicare and Medicaid Cuts

We are concerned about the proposed level of Medicare and Medicaid cuts. Specifically we are concerned about the proposals to further reduce the update by 1%. We believe that the diagnostic criteria which define exclusion of rehabilitation hospitals from the PFS should be expanded. We will bring a specific

proposal to the Subcommittee shortly. Finally we wish to see the proposal regarding placing SNF limits on long term hospitals clarified.

7. Prevention and Research Initiatives

The health research initiatives include prevention research on unintentional injuries, cognitive development and chronic and recurrent illnesses. Priorities for health services research include quality and outcomes research; workplace injury and illness prevention research and demonstration programs; and long term care research focusing on new models to expand the range of financing and administration.

Rehabilitation plays a major role in prevention of injury and disability as noted in attachment A.

Recommendations:

NARF supports:

- a. Continued efforts to promote seat belt and helmet laws, smoking cessation and all efforts to control violence, especially gun violence.
- b. Health research to develop quality and outcomes measures, especially in rehabilitation;
- c. Prevention research especially in the areas mentioned above;
- d. Programs promoting wellness, including wellness and injury prevention in the work site and in the home; and
- e. Continued research into long term care.

8. Risk Adjustment

Under the Plan, health alliances are to use a risk adjustment formula developed by the National Health Board to determine payments to health plans. These are to reflect a plan's patient population related to age, gender, family size and health status. Disability is not now included.

Recommendations:

- a. Add functional ability to the list of factors used for risk adjustment. Any possible disincentive for enrollment or referral for services should be removed. An appropriate risk adjustment formula is one factor in removing such disincentives.
- b. Rehabilitation providers and persons with disabilities must be represented on the Advisory Committee for the Risk Adjustment System.

9. Workers Compensation

Health plans would provide for medical benefits, including rehabilitation and long term care services for work related injuries and illness. Plan would employ or enter into contracts with specialists in industrial and occupational therapy and provide access to specialized providers or centers of excellence in industrial medicine and occupational therapy. Alliances can subcontract with health care professionals and institutions to provide specialized services on behalf of plans serving the alliance. Plans are reimbursed by the state workers comp system according to a fee schedule set by the alliance. The fees schedule would include rehabilitation, long term care and other services commonly used to treat injured workers. Health benefits for injured workers would continue to be defined by the states. However state laws regarding choice of providers for injured workers will be preempted with respected individuals enrollees in the alliances, although exceptions may be necessary. The health plan's performance in treating work related injuries and illness, including facilitating injured workers' returning to work, will be included in the quality information report.

We support the recognition of the critical role rehabilitation places in returning people to work.

Recommendations:

- a. The workers compensation program component must acknowledge the diversity of state laws to assure that those states that cover vocational as well as medical rehabilitation services, which may be beyond the plan's coverage, are recognized and covered.
- b. The programs that can contract with the plan to provide a return to work services should include those for occupational medicine, and medical and vocational rehabilitation services as well as occupational therapy.
- c. Long term care services provided under workers compensation programs must include the support services someone needs due to a work related disability.
- d. Rehabilitation must be included in the focus of the Commission on Health Benefits and Integration.
- e. Rehabilitation providers should be included in the Commission on Health Benefits and Integration and as consultants to the Departments of HHS and Labor to develop protocols for the appropriate treatment of work related conditions.

10. Long Term Care Services for Persons with Disabilities

A new long term care program would be created through the Social Security Act. It would expand home and community based services to persons with severe disabilities without regard to income or age. People would be eligible if they could not perform 3 out of 5 activities of daily living; have a severe cognitive or mental impairment; have severe or profound mental retardation; or if, under 6, were dependent on technology and would otherwise be in a hospital or other institution. Benefits would include a standardized assessment and individual plans of care. Personal assistance services would be available. At the states option, they could include a range of critical services including rehabilitation and habilitation. This is a valiant effort to tackle an enormously difficult problem. However, since many of the services

may be offered at a state's option, and there will be a national expenditure ceiling, states may not be able to deliver services that a person is identified as needing through the assessment and in the plan of care.

Recommendations:

- a. NARF supports recognition of cognition as an eligibility factor. NARF supports a standardized assessment and individual plan of care. NARF supports coverage of personal assistance services as a required benefit under the home and community based services program in addition to an assessment and plan of care.
- b. The number of ADLs should be expanded to include mobility and communication.
- c. NARF is concerned, however, that states will not be able to adequately finance the program to assure that all persons who are eligible for and need services will be able to receive them. We will have additional recommendations when we see the final plan.

11. Tax Assistance for Persons with Disabilities who Work

The plan proposes to provide a tax credit up to 50% or \$15,000 for personal assistance services for persons with disabilities who want to work. This proposal would be a great help to people who want to work but need assistance to do so and to facilities that train people for employment and placing them in jobs.

Recommendation:

NARF supports this proposal.

12. Rehabilitation Professionals

Priority projects include primary care loans for students in targeted allied health professions, e.g. physical therapy. Another priority project is training providers in geriatrics, prevention and developmental disabilities. There will be an emphasis away from specialty physician training. However psychiatry is a shortage specialty. There will be an emphasis on training other rehabilitation professionals.

Recommendations:

- a. NARF supports all efforts to expand programs, faculty and financial support for those who wish to become rehabilitation professionals: nurses, physicians, physical therapists, occupational therapists, speech-language pathologists, respiratory therapists and others.
- b. NARF supports programs to train rehabilitation physicians who wish to be primary care physicians for persons with disabilities.

13. Outcomes and Quality Management Program

One of the many functions of the National Health Board is to establish the National Quality Management Program. States, alliances and plans will have different responsibilities under this program. One aspect of this program will be outcomes.

Rehabilitation has been actively developing tools for measuring outcomes for the past ten years and could be a strong contributor to developing outcomes information and measurement.

Recommendations:

- a. The outcomes information requested should include improvement in physical and cognitive functions as well as vocational and living status.
- b. Rehabilitation providers, should be members of, and work with, the National Advisory Committee and each state, alliance and plan in developing the outcomes information requested.
- c. Persons with disabilities should be represented on the national advisory committee and any other committees charged with developing the quality management program.
- d. Rehabilitation providers must be included in the development of practice guidelines and utilization protocols at the National Health Board, alliance and plan levels.
- e. Data collection and outcomes research on the efficacy of health care should include the work of rehabilitation providers. Rehabilitation providers should be included in the design and conduct of such research which should focus on the resulting quality of life of patients.

14. Long Term Care Insurance

The plan includes incentives for private long term care insurance and for establishing federal regulations of such insurance. Such insurance will help those who can afford it purchase needed rehabilitation services in the home and other settings. The standards for such long term care insurance requires coverage of therapeutic, rehabilitation, maintenance and personal care services.

Recommendation:

- a. NARF supports development of long term care insurance and recommends the proposed benefits include rehabilitation and preventive services.
- b. Transportation should be added as a covered service.

15. Administrative Simplification

Several changes are proposed including one payment form, unique identification numbers and streamlining Medicare. The NHB would try to develop standards for a single annual inspection of providers to replace the multiple federal, state, local and private accreditation survey and certification agencies.

Recommendations:

NARF supports administrative simplification but with the caveat that if there are any associated costs, that they are reimbursed to the providers. Furthermore, for smaller rehabilitation providers, adequate time and funds must be available to allow them to switch to electronic billing.

Attachment A.

CURRENT COVERAGE OF REHABILITATION*Coverage of Rehabilitation Services is Standard in Today's Insurance System*

Rehabilitation services are a standard benefit in most health insurance packages offered by both public and private payers. Americans have come to expect that the range of therapies needed to improve their functional capacity and autonomy will be provided. Notwithstanding the wide diversity of health care payers in the U.S., virtually all of them cover rehabilitation therapy in one form or another. This is true in both the public and private sectors.

- **Medicare** — The federal Medicare program covers occupational and physical therapy, speech-language pathology and audiology, respiratory therapy, social work services, rehabilitation nursing and psychology in a range of inpatient and outpatient settings. The program also provides coverage of items that are frequently essential to rehabilitation care including orthotics (braces and splints), prosthetics (limbs), and durable medical equipment. Providers recognized under Medicare include rehabilitation hospitals, rehabilitation units in general hospitals, rehabilitation agencies, clinics, nursing facilities, CORFs, and home health agencies.
- **Medicaid** — Rehabilitation services also are covered within the Medicaid program. Every state Medicaid plan covers rehabilitation services when provided within a hospital (both inpatient and outpatient), nursing facility, home care, or under the Early and Periodic Screening, Detection and Treatment (EPSDT) program, since coverage of each of these benefits is mandatory under federal law. With respect to optional Medicaid benefits, rehabilitation services may be covered when provided by clinics, rehabilitation agencies, CORFs, and independent practitioners. Most states have chosen to furnish rehabilitation services in these optional settings. However as many states face severe budget problems, we find that the availability of these services or simply any payment (whether mandatory or not) for them is being cut back.
- **Black Lung** — The Black Lung Program, which provides federal assistance to coal miners and their dependents, has covered and reimbursed outpatient pulmonary rehabilitation since 1978.
- **State Mandatory Coverage Laws** — Several states have enacted legislation mandating coverage for specific rehabilitative services. For example, Delaware and Louisiana have recently passed laws requiring coverage of physical therapy, speech-language pathology and audiology services, and occupational therapy. Rehabilitation services are mandatory in one form or another in Connecticut, Maine, Massachusetts, West Virginia, Missouri, Texas, Tennessee and Arkansas.
- **Private Insurance** — The private health insurance industry also routinely offers coverage of rehabilitation services. While insurers may limit the number of rehabilitation visits covered or apply an annual monetary cap, very few limit coverage by specific diagnosis or clinical indication. Most plans require that rehabilitation services be ordered by a physician and furnished by providers having specific credentials. For example, many plans will cover physical therapy only if provided by a licensed physical therapist.
- **Blue Cross/Blue Shield Plans** — Based on an informal national survey, it is clear that respiratory therapy, speech-language pathology services, audiology, and physical and occupational therapy services are commonly covered by the Blue Cross/Blue Shield plans in the country. In particular, while the scope of coverage varies by plan and insurance product, physical and occupational therapy are routinely covered, and speech-language pathology services and respiratory therapy are usually covered subject to certain limitations (e.g., limited diagnoses, duration, and/or settings).
- **HMOs** — Rehabilitation therapy is also covered somewhat in the HMO market. The 1992 HMO Industry Survey conducted by the Group Health Association of America included questions on rehabilitation coverage for the first time. The results showed that most HMOs, regardless of their federal qualification status, cover some rehabilitation services.

While individual services have been covered by HMO's, there have been some problems with the delivery of rehabilitation services. The regulations implementing the HMO Act require federally qualified HMOs to offer services as follows:

- "(a) An HMO shall provide or arrange for the provision of basic health services to its members as needed and without limitations as to time and cost other than those prescribed in the Public Health Service Act and these regulations, as follows:
- (iii) Outpatient services and inpatient hospital services shall include short term rehabilitation services and physical therapy, the provision of which the HMO determines can be expected to result in the significant improvement of a member's condition within a period of two months." 42 CFR 1701.101

The major problem is in the interpretation of this regulation. Nonqualified HMOs set their own limits.

Many plans interpret one therapy visit as a day of service, which eventually exhausts the benefit prior to the patient receiving the comprehensive rehabilitation services needed for a complete recovery. For example in California two men had a similar spinal cord injury. After five months in therapy, one man recovered and is back at work and with his wife and family. The other man abruptly left rehabilitation. The first man found out that his colleague left rehab not for any medical reason, but because his HMO would only cover 60 days of care. According to the first man, it sent the second man to a rest home where he received no therapies, was in bed and turned once a day. All the gains he made in rehabilitation were lost and he was totally dependent.

Some HMOs do not refer to a comprehensive acute rehabilitation program as a matter of practice, even though the patient may readily meet the admission criteria. NARF have also recently heard that a large risk based HMO will not refer stroke patients to acute rehabilitation but instead is sending them to a nursing facility without the benefit of intensive rehabilitation therapy. This rule of thumb may not be appropriate for all stroke patients.

COST EFFECTIVENESS OF REHABILITATION SERVICES

Rehabilitation services are viewed as cost-effective for the following reasons:

- *Rehabilitation services return patients to productive lives* – rehabilitation is one of the most effective forms of prevention for survivors of serious illness, disease and injury. Through physical, social and cognitive restoration programs, rehabilitation prevents them from becoming persons with permanent or long-term disabilities. It assures that any residual impairment does not become a disability affecting an individual's activities.
- *Rehabilitation prevents complications* – Rehabilitation is also well known for its efficacy in preventing complications and subsequent re-hospitalization, which can be very costly. For example, rehabilitation helps prevent deep vein thrombosis, cardiac involvement, pressure ulcers, contractures, pulmonary emboli, and emotional dependence and depression.
- *Rehabilitation speeds recovery* – Several studies show that stroke patients who receive rehabilitation have better outcomes than those who do not. Additionally, they indicate that stroke rehabilitation patients are more likely to be discharged to home than to long term institutionalized care. They are also likely to live longer and are more likely to retain a higher level of function and activity. A 1981 study found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus a long term residential institutional setting saved \$13,248 per year, in 1981 dollars, or \$20,447.61 in 1992 dollars per year. Given that the average stroke patient lives over 5 years, this is a savings of \$102,238.12 in 1992 dollars.
- *Rehabilitation maximizes the restoration of functional capacity* – Rehabilitation can help consumers adapt to a physical challenge and lead a more independent life. To understand the impact of rehabilitation, consider a daily example: dressing independently. Many older spouses and family members do not have the physical strength required to assist a loved one in this daily routine. The consequences of employing a nurse or aide, if available at all, to assist in this daily process can be costly and discouraging. In a study of 329 rehabilitation patients, 245 required total or maximum assistance to dress on admission. At discharge, 156 required only a minimal level of assistance. If we assume that helping someone dress requires half an hour a day, then the improvement of 156 patients to require only a minimal level of assistance (which could be provided by a spouse or family member) would save 28,470 hours per year. If a minimum wage of \$4.25 applied to each individual needed to help a person dress, an annual savings of \$120,997 could be realized. This does not acknowledge travel time either. Similar logic can be applied to the savings that result from a rehabilitation patient's attaining independence in other areas of daily life. These include independent locomotion and the management of bladder skills, which can reduce the risk of infection and the need for further medical intervention.
- *Preventive rehabilitation improves workplace productivity* – The benefits of rehabilitation start with injury prevention in the workplace. Through workplace prevention, rehabilitation saves countless health care dollars as well as lost hours of productivity. Some rehabilitation professionals specialize in working with employers to examine work sites, identify hazards and eliminate the potential for work-related injuries. The Public Health Service estimates that in 1989 there were 192 cases of cumulative traumatic disorder (just one kind of work-related injury) per 100,000 workers. These disorders affected workers who engaged in repeated wrist-twisting motions, from computer users to meat cutters to grocery store check-out clerks. The involvement of rehabilitation professionals in the workplace can help reduce the incidence of these cumulative traumatic disorders through modification of work stations, analysis and improvement of the motions used in work (particularly in repetitive working situations) and by coaching good lifting techniques. These precautions help prevent workplace injuries and the need for more major medical intervention. These savings are particularly important since workers comp costs are increasing at a rate of over 20% a year, and creating a tremendous burden for many businesses.

ATTACHMENT B.

PROPOSED PLAN STANDARDS/CRITERIA

Congress, in its directions to the National Health Board, the states, alliances and plans must establish standards or parameters that states must meet and that they will require the alliances and plans to meet before the Board will approve a state's plan. These criteria presume that rehabilitation services are covered in the national benefits package at least as proposed by the President's plan.

1. Each plan must have direction and incentives to deliver medically necessary services. One way to do so is require that when an enrollee sees a primary care provider, the primary care provider must perform a rehabilitation evaluation within 72 hours for patients who fall into the diagnoses most commonly treated by rehabilitation or have a congenital disability. These diagnoses include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

A second way to do so, and to reinforce the first, is require education for primary care providers on physical medicine and rehabilitation. It should be a requirement of their curriculum.

2. Plans must deliver medically necessary rehabilitation services. The standard for medically necessary care must include factors relating to the medical condition of the patient, needed therapy and ancillary services, intensity of medical supervision required and intensity of nursing. Additional factors include improvement in functional capacity, prevention of deterioration and prevention of secondary complications and disabilities.

3. Plans must demonstrate that any financial rewards must be for the appropriate referral for diagnostic and specialty rehabilitation services.

4. Each plan must demonstrate where services will be available so that a full continuum of rehabilitation services is available to enrollees.

5. The total quality management program must include an audit to see if patients with typical rehabilitation diagnoses are referred for rehabilitation services.

6. Plans must allow all enrollees who have disabilities to choose a physiatrist or other qualified rehabilitation physician as their primary care provider.

7. Plans must be required to develop (a) maximum waiting periods for appointments, both initial and followup and referrals to specialists and (b) standards for maximum travel distances.

8. Plans must assure that the grievance and appeals procedures be available to both enrollees and providers; that they include short timelines for review of a service denial; and they are clearly communicated to all parties. Plans must have procedures for obtaining an independent second opinion promptly when covered benefits are denied for any reason.

9. In specific cases, a patient should be allowed to go out of plan for specialized covered services.

10. If the plan uses case managers, the case managers working with enrollees who need rehabilitation services must be knowledgeable, trained and educated in rehabilitation.

11. Plans must involve rehabilitation providers in the development of utilization review procedures and practice guidelines.

Mr. KLECZKA. Thank you for your testimony.

Ms. Yosko, you mentioned your experience with managed care. One of the key elements of the President's plan is the reliance on the managed care concept.

Could each of you describe your experiences with managed care? I know you have just voiced some reservations.

And also, if you are familiar and have contracts with plans, how do you set up the fee structure? And what do you consider before signing up with a specific plan?

Do you want to start, Ms. Yosko?

Ms. YOSKO. Sure. We support the notion of managed care. However, what we are concerned about is that the full continuum of care be available to patients within the plan, and that patients with more complicated disabilities be able to be placed in the most appropriate setting so that their outcomes can be most beneficial. Those settings range from the hospital setting all the way into home care.

With respect to how we have worked with managed care, currently we have about 33 HMO and PPO contracts, so we have been very willing to participate. At Schwab we have a very unique population of patients in that we treat an 87 percent mix of government-reimbursed patients, that is, Medicare and Medicaid mix.

We have found, though, that with at least the contracts that we have currently, it has been a very positive experience. But that is not the case in all States. Sometimes we find that patients who could have better outcomes in a rehabilitation facility or hospital are placed directly in a nursing home and then lost in the system. But that is not to say that a nursing home could not be an appropriate placement for some patients.

Mr. KLECZKA. Could all members of the panel respond to that?

Ms. FONTENOT. Yes. As far as the managed care plan at our particular hospital and the six hospitals that I represent, approximately 30 percent of our revenue comes from managed care plans.

At Woman's Hospital in Baton Rouge, we are currently under contract with 20 different plans. And I agree with Ms. Yosko that it is important that the care be delivered in the appropriate setting; and if it is a lower-risk routine care, a community hospital or outpatient may be appropriate.

However, in more specialized situations, then, the care needs to be dedicated to a regionalized setting or something like that—with more tertiary-type subspecialty providers. As far as the types of contracts that we have entered into as a percent of charges, per diems and case rates as well, and as far as determining which contracts we are going to enter into, it mainly has to do with the ability to provide the quality and level of care that the patient is needing and also their willingness to work with us on the special types of cases that we provide care for.

Mr. KLECZKA. Thank you.

Mr. Goldberg.

Mr. GOLDBERG. My experience with our rehabilitation patients is the same as that as Ms. Yosko just expressed.

However, our long-term patients, long-term medical hospital patients, are very complex; and we have contracts with managed care

organizations on an average, per diem basis as well as on a discount from charges. And we share the risk.

We make an estimate of an average basis as to what we think a medical patient would cost or a ventilator patient or a rehabilitation patient, and so far it is working out very well. We can live with that.

Mr. KLECZKA. So that portion of the President's plan causes you little heartburn?

Mr. GOLDBERG. About the managed care? That doesn't bother me at all, except for the fact that if it remains with aggressive insurance companies, the question of access for the most disabled will be a problem.

Mr. KLECZKA. OK. Mr. Trachtenberg.

Mr. TRACHTENBERG. I think there is the good, the bad, and the ugly. And our members have experienced all three kinds. In the last couple years, the experience with managed care has been rather good, we think.

There are outlier examples where a managed care company forces a patient out of a hospital who is clearly still suicidal. And in those cases the hospital just holds the patient and eats the cost of the care.

But, basically, our major concern, as this moves forward—and we support the concept of managed care—is that much of the health care is going to work through at risk arrangements, HMOs, and similar organizations.

And our concern is that, in these kinds of situations, where the dollar is at risk, there is a great potential that patients with chronic illnesses—severely mentally ill in our case—will not be adequately treated. There will be a tendency toward under treatment.

That is why we think it is so important to be able to develop specialty mental health services where you have real expertise in terms of dealing with this very chronic and severely ill patient.

But I think it is evolving, and I think, overall, we can live in a managed care environment if we can have an adequate mental health benefit and there is no undertreatment of the patient.

Mr. KLECZKA. Mr. Kushner.

Mr. KUSHNER. From the perspective of the osteopathic hospitals, our biggest problem with managed care has been access to the managed care contracts. In the last couple of years what has happened for us is that in many cases the managed care companies will come into a community, will quickly in a sense almost cherry-pick 2 or 3 of the largest institutions and will exclude the smaller osteopathic hospitals, ultimately very much affecting their bottom line and their ability to compete.

We see the need in the future to compete in the managed care environment, but what we are looking for is some protection that would allow the osteopathic hospitals to be considered in the managed care plans and to not be arbitrarily excluded, many times on the basis of accreditation status alone.

I should point out to you that a number of our hospitals have moved from having the American Osteopathic Association accreditation as their sole accreditation, which gives them deemed status under the Medicare law, to also seeking Joint Commission accreditation, because in many cases the managed care providers will only

look at the Joint Commission. What that does, in fact, is actually increase the cost of providing the health care, because those institutions are required to have AOA accreditation in order to be teaching sites for AOA programs and now also have to incur the cost of Joint Commission accreditation in order to be accepted by the managed care providers.

They enter that marketplace then at a disadvantage because they are having to carry dual accreditation and incur the costs for both. It is essential for them to continue to be AOA accredited because, for 75 percent of our member hospitals, graduate medical education is a primary activity that they undertake.

So we recognize the trend for the future but are very concerned about the issue of access.

Mr. KLECZKA. OK. Thank you very much.

Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Let me just thank members of the panel for being here. I don't have any questions. Thank you.

Mr. KLECZKA. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I apologize for not being here for your testimony. I obviously am reading it and am anxious to hear from you.

Given the narrower focus of your hospitals in terms of the larger health care needs, one of the concerns that I have had, carrying over from the previous administration and working with Gail Wilensky when she moved from HCFA into the White House structure and was working with Department of Justice, was the removal of what I consider to be some pretty archaic barriers in the anti-trust area.

The administration has recently moved forward with some long overdue and, in my opinion, probably not as broad a scope antitrust reforms, and I just need to get some kind of a feeling from you folk as to whether or not those feelings are accurate or not.

Do you believe, if you have looked at them, that the administration suggested changes are enough? Do you have any ideas that, if they are not, would help you do a better job today? We are talking about fundamental reform in the health care area, and it seems to me that we probably have not focused as much on the health care professionals who aren't allowed under the law to talk to each other as much as they should to make sure that—not only in terms of new technology—that we get the best dollar deal, just in terms of some basic old-fashioned ways of relating. We probably could do that when we weren't as cost conscious. It probably wasn't a good idea then. But given the law you went ahead and did it.

Any reactions at all to the whole area of antitrust and whether what has been suggested is adequate enough or whether you have some particular suggestions that might be useful given your perspective based on what you do? Anyone at all.

Mr. TRACHTENBERG. Mr. Thomas, speaking for the psychiatric health systems that I represent, we think that is moving in the right direction. I think we all need to recognize that the health care delivery system is reforming in front of our very eyes without the first piece of Federal legislation having been passed. And every day another one of our hospital systems is merging into a larger health

care system that looks like it will form into some form of accountable health partnership.

And, as we look at the antitrust interpretations that the Justice Department says that they will be making, we think that that can work without any special particular changes in the law. I think it has to be carefully watched because I think you do run the risk eventually, if it is too flexible, that you will have maybe five insurance companies and 2 or 3 large hospital systems controlling the health care system for 80 percent of the market. But at this point, I think they are on the right track.

Ms. FONTENOT. I also have some comments in my written testimony regarding the antitrust legislation and the plan, and it does seem to be going in the right direction, too.

I would agree, as far as women's and infant specialty hospitals, we have seen in our communities where it has eliminated duplication of services and expensive technology. For example, in our particular facility, we don't have an MRI and we are just getting around to getting a CT scan. We have been able to do without that expensive technology by working collaboratively with other hospitals in our community and so have many of the other hospitals.

To not allow for some sort of antitrust reform obviously impedes that ability to do those kinds of things. We believe also that relaxing antitrust issues would provide for a more seamless system for patients. They would be able to move easier between hospitals to get the services that are needed rather than each hospital having to build their own little empire.

And then, finally, I think it will lead to overall reduction of the cost of care. I don't think it is going to provide for more monopolies. I do believe it will reduce the cost of care.

Mr. THOMAS. One of my concerns, and I think you are right, Mr. Trachtenberg, that you have got to watch it in terms of a flexible consolidation in which some larger folks can gobble up the rest of them. But my concern moves more in the direction of Ms. Fontenot, and that is, if you don't have a creative way in which professionals can resolve the problem, you are not going to have a structure which enables you to come up with the new creative initiative structures that involve professionals in the decisionmaking structure, perhaps in ways that they are not involved now.

Because, frankly, you can have the best system in the world on paper but if the professionals who are supposed to deliver the service are being told to do it in a way or under a structure in which they are chafing and don't feel very comfortable, you are not going to get the kind of results you want.

One of my worries was that, as we were moving forward, some of the initial structures, as I understood them in talking with Ira Magaziner and others, is that professionals, in fact, may have the potential of being locked into that kind of a structure.

I think in the short run that an examination of the antitrust area will be a safety valve which will allow for creative reorganization, and you are going to have to monitor it, but I would much prefer the opportunity for professionals to consult with each other, doctors, hospitals, drugs and the rest, so that there is a comfort level among the professionals that not only do they see a future in

the system but that the decisionmaking structure is one which clearly involves them, bringing the efficacy of choice.

Mr. TRACHTENBERG. There are, Mr. Thomas, a lot of interesting legal entities developing out of all this. Physician hospital organizations is one, where physicians and the hospitals come together with a mutual interest in terms of going, you know, after a managed care market. There are management service organizations. There are nonprofit foundations being set up. There are group practices without walls. There is a whole range of different, unique entities to bring the professional closer with the provider of care, the hospital or the hospital system.

Mr. THOMAS. I think that has a better chance of solving our problems than someone in Washington dictating a particular structure that all are going to have to follow without an ability to allow those people who, after all, have focused and dedicated their lives to do just that; having a major say in the structure that is going to be followed.

Thank you all very much.

Mr. KLECZKA. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

Your testimony has been very helpful because a lot of us do worry about your kind of folks. I have a very good rehab hospital in my district and have worked on rehab issues for a long time. I am very, very interested in the quality of mental health services that will be available to our folks. And I appreciate the quality of your comments and also your experience in managed care.

I think we do have the good, the bad and the ugly still, and the goal is to try to create a system that will support the good and penalize the ugly, so that they gladly die of their own weight.

I would ask two things. First of all, Mr. Trachtenberg, you made the comment in your testimony that you can control mental health costs in a truly competitive environment but that you oppose premium caps and heavily regulated health alliances. I would ask you to start in response to my question, but the others as well.

You may not be aware of this, but in the President's plan, that is, the outline that we currently have, and so these are things that I ask you to look at in the weeks ahead and get back to us on, but it specifically says that the health alliance may make the global budget available to the companies before they bid premiums on the basic health plan that they are required to propose.

Now, you will remember that in the President's plan that global budget declines very steeply. In fact, over 3 years it cuts Medicare spending in half. But it declines very steeply in general.

Another part of the President's plan that isn't as familiar yet to people are the new costs that he loads into the premiums. The premiums are going to pay. Carries a 2 percent component for the administrative costs of the health alliance. The premiums are going to carry another 2 percent for nonpayment of premium by people for companies that get into financial trouble and so on and so forth. And then there is another 2 percent that they are going to load into the premium for medical education.

So those costs have never been carried by premiums before. So not only are the premiums going to be under pressure of the global budget but part of the premium base is going to go to nonpatient

care needs and to nonadministrative costs of the particular accountable health plan.

So I hope you look carefully at what you think will be left of the premium and what that kind of premium will do to the kinds of services that you offer. And, how can we support a kind of competitive system that will get rid of the ugly and support the good and, what are the alternatives to this kind of premium setting structure that, without question, will radically cut the amount of money available for actual care?

Mr. TRACHTENBERG. It is a profound question. I am not sure I have a profound answer for it.

I think in the psychiatric field the one thing that is clear is that the systems have evolved into continuums of care, and that more and more now people are being placed in the least expensive, least restrictive level of care. That has been really brought about by more enlightened insurance companies, more enlightened managed health care companies, where people are not putting patients in psychiatric hospitals but providing partial hospitalization program, outpatient, home health care and things of this nature. That is a very positive trend which I think will have to continue.

I think that, given that full continuum—and it has to be very seamless. It has to be well integrated. But, given that kind of continuum of care, I think if we were able to develop a health care dollar, a mental health care dollar as a percentage of the total health care budget that people would compete around, and if that amount was adequate—and when I talk about adequate, I am talking about somewhere in the order of 10 to 12 percent of total health care costs—that we could pretty much cover most of the or just about all of the psychiatric mentally ill patients, and that is the range from the more difficult, severe patients through patients who are less severe.

I think you can do this in some kind of at-risk arrangement because I don't think you can do it in a fee for service or other kind of even per diem type arrangement.

But I think there is a potential for doing it, and I think we have to be encouraged by the fact that mental health costs as a percentage of total health care costs has really stayed pretty steady over the last several years. And, in fact, in this past year Foster Higgins reported that we were significantly below the inflation level for medical care costs.

So there is a lot of activity going on, a lot more cost consciousness going on. And as these broader systems of care develop I think we have the potential of managing within a reasonable amount. But that amount has to be reasonable, and it has to be available for mental health care.

When you are in a field like mental health where the standards of care are not as clear as they may be in some of the more physical health care areas, there is a lot of opportunity for gaming the system, for undertreating patients. And, therefore, we feel very strongly that we have to in the mental health area develop Federal criteria for participation.

I don't want fly-by-night companies coming in and underbidding and providing, as, for instance, HMOs spend about 2 to 3 percent of their health care dollar on mental health services. That is too

low, and it is ridiculous, and I don't think there is enough care that can be given for that kind of dollar, certainly not for severe patients. But I think a Federal system of credentialing these providers and finding out what they are going to spend for inpatient, partial and for other services, per thousand lives or whatever, will go a long step in that direction.

Mrs. JOHNSON. Interesting. Any other comments?

Mr. GOLDBERG. I would like to say that my major concern is rationing, and that the decisions—the most expensive patients that we deal with, the survivors of neonatal intensive care or the elderly or those accident victims who become very disabled for life, are highly vulnerable to being rationed against. And I would prefer that those rationing decisions be made by the Federal Government rather than by an insurance company.

Mrs. JOHNSON. That is an interesting comment.

Ms. YOSKO. I think, again, with respect to rehabilitation facilities, our concern has been, as I mentioned in my comments, about the business of really making sure that the full continuum of care is supported and that there isn't an effort to cost shift to lower cost settings based on the availability of funds. I think the way the plan is stated currently, that certainly the levels of care are inclusive in the plan, but as to where the money is going to come from for the plan and when it is going to get ratcheted back—that is our concern, to make sure that specialty hospitals and services don't somehow get eliminated or will just not be provided.

Mrs. JOHNSON. Thank you.

Would you like to make any comment?

Ms. FONTENOT. I would agree with that. We are concerned also as a specialty provider that the maintenance of our volume base is preserved, that it is not eroded away to community hospitals for the lower cost type cases that we do.

Mrs. JOHNSON. Certainly my experience has been that you are better able to work with providers out there in the real world so that your specialty services do get integrated appropriately. And if we try to do that from Washington, particularly through the blunt instrument of premium setting, it will be very, very difficult for you to survive. And that certainly is true in mental health services.

Thank you for your testimony.

Mr. KLECZKA. Let me also thank the entire panel for appearing today. I should point out that the copy of your entire statement will be made a part of the record.

Let me welcome the fifth panel which represents hospitals and other facilities.

Let me welcome Vicki Romero, president and chief executive officer of the Woman's Hospital in Baton Rouge, La.; Dr. Charles Balch, representing Memorial Sloan-Kettering, the M.D. Anderson Cancer Center and other facilities specializing in cancer treatment; Lewis Molnar, executive vice president of the Shriners Hospital for Crippled Children; John Forsman, chief financial officer of the Community Medical Center in Toms River, N.J.; Beth Derby, an R.N., president-elect of the Federated Ambulatory Surgery Association; and also Dr. Gumnit, president of the National Association of Epilepsy Centers.

Let me start off with Ms. Romero.

Again, I would like to indicate to the witnesses that copies of your entire testimony will be made a part of the permanent record, so if you would proceed and summarize your statements, we would appreciate it.

STATEMENT OF VICKI ROMERO, PRESIDENT AND CHIEF EXECUTIVE OFFICER, WOMAN'S HOSPITAL, BATON ROUGE, LA.

Ms. ROMERO. Thank you, Mr. Chairman.

I am Vicki Romero, president and chief executive officer of Woman's Hospital, a 225 bed not-for-profit regional perinatal center located in Baton Rouge, La.

As a leading specialty provider in America, Woman's Hospital views health care reform as both an opportunity and a possible threat: An opportunity to provide the same quality of health care to all Americans at a cost-effective manner and to ensure that women's health care needs are fully addressed; a possible threat to the continued viability of specialized providers such as Woman's Hospital.

Undeniably, low-income populations generally receive lesser quality health care in America due to a variety of reasons, including lack of access. This reality is illustrated in the Baton Rouge area where the rate of infant mortality in a local charity hospital is 30 percent higher than at Woman's Hospital. The higher infant mortality rate at the charity hospital in all likelihood is attributable to low birth weight babies which generally result from the lack of prenatal care.

Specialty hospitals such as Woman's Hospital are committed to reducing barriers to prenatal care through prenatal education. For every dollar spent for prenatal care for high-risk, low-income women, \$3.38 is saved in hospital costs alone by avoiding high-cost intensive care and/or rehospitalization.

Indeed, quality care is cost effective. Woman's Hospital's cost and charges average 30 to 40 percent below regional and national averages and, according to Blue Cross of Louisiana data, are lower than other providers in the Baton Rouge area and in Louisiana.

Cost effectiveness in delivering care is directly related to the economies of scale for high-volume services. The first 25 percent of births in any hospital are more expensive to perform than the last 25 percent, since those fixed costs are spread over higher volume.

Unless carefully designed, health care reform could undermine the opportunity for all Americans to have access to quality, cost-effective care offered at specialty institutions such as Woman's. For instance, under certain proposals, including the President's, health care reform would provide for the formation of government-certified health plans to serve all Americans. Unless mechanisms are established to assure that the role of specialty hospitals is preserved in these health plans, Woman's Hospital and others like it risk losing their base of the high volume, routine services which are necessary to sustain the quality, cost-effective routine and specialty services offered at our institutions.

For instance, in Louisiana, the charity hospital facility in Baton Rouge is in disrepair. The leading proposal to address this problem is to build a new facility at an approximate cost of \$48 million. Woman's Hospital is proposing to provide a full range of health

care services from primary care to the most sophisticated care on a contract basis to the charity system, which would save \$17 million in construction costs alone and to work with the State to ensure that a network of primary care outpatient clinics, including school-based clinics, are in place to ensure access to all women.

However, the State has indicated that it intends to build the new facility and not utilize the full range of services available at Woman's Hospital. This action would duplicate services already available at Woman's and could potentially redirect a significant percentage of Woman's Hospital's patient base to the new facility, yet Woman's depends on the patient base for its financial viability and excellence of service.

The preliminary draft of the President's health care reform plan references the creation of a category of designated specialty providers and provides that States may establish requirements for health plans to assure access to services, including a requirement to reimburse or contract with the designated specialty providers and centers of excellence. This is an encouraging statement.

Any reform initiative must define designated specialty providers to include institutions such as Woman's that provide specialty care as well as primary and secondary services. Health plans should be required to contract with designated specialty providers for the entire range of health care services from primary care to the most sophisticated because, without the high volume, routine patient base, specialty hospitals would not be financially viable and could suffer in quality.

Finally, in geographic areas with designated specialty providers, other providers should be required to formally demonstrate need before any new facilities could be built or beds designated for the services already provided by the designated specialty providers.

I would be pleased to answer any of your questions and provide you with additional information. Thank you.

Mr. KLECZKA. Thank you for your testimony.

[The prepared statement follows:]

TESTIMONY ON BEHALF OF WOMAN'S HOSPITAL
BATON ROUGE, LOUISIANA

TO THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
October 26, 1993

Thank you Mr. Chairman. I am Vicki Romero, President and Chief Executive Officer of Woman's Hospital, a 225-bed not-for-profit regional perinatal center located in Baton Rouge, Louisiana. Woman's Hospital was one of the country's first hospitals to provide health care to newborn infants and women of all ages and in all stages of life. Our medical staff of 500 represents 55 medical specialties, including neonatal intensive care, neonatal surgery, gynecologic oncology, high risk obstetrics and an array of women's highly specialized services.

As a leading specialty provider in America, Woman's Hospital views health care reform as both an opportunity and a possible threat: an opportunity to provide the same quality of health care to all Americans in a cost-effective manner and to assure that women's health care needs are fully addressed; a possible threat to the continued viability of specialized providers such as Woman's Hospital.

Undeniably, low-income populations generally receive lesser quality health care in America due to a variety of reasons, including lack of access. This reality is illustrated in the Baton Rouge area. Woman's Hospital is located only six miles from a state-owned charity hospital. Woman's delivers 6,000 babies annually, 1,700 are Medicaid deliveries; the charity hospital delivers 2,600 babies annually, virtually all Medicaid-reimbursed. The rate of infant mortality at this local charity hospital is 30% higher than at Woman's Hospital where we already have achieved an infant mortality rate of 6.65 per 1,000 births, far below the national goal of 7 per 1,000 births set for the year 2000 by the Committee on Perinatal Health. The higher infant mortality rate at the charity hospital, in all likelihood, is attributable to low birthweight babies which generally result from the lack of prenatal care. Barriers to prenatal care include lack of financing, health provider capacity shortfalls, lack of user-friendly services, and social isolation.

Specialty hospitals such as Woman's are committed to reducing barriers to prenatal care through prenatal education. Woman's Hospital's commitment to prenatal care is evidenced by our stated mission which emphasizes the provision of quality medical and educational services. For every dollar spent for prenatal care for high risk, low-income women, \$3.38 is saved by avoiding high cost intensive care and/or rehospitalization (Southern Regional Project on Infant Mortality). This amount relates to hospital costs only; undoubtedly, the societal and educational costs are immeasurable.

Woman's Hospital originally was financed with seed money from one of the nation's first cervical cancer detection laboratories. Since the opening of this facility in the 1950s, over 1 million PAP smears have been performed, resulting in a cervical cancer mortality rate of only 1.2 deaths per 100,000 patients treated at Woman's Hospital as compared to a rate of 9.1 deaths per 100,000 patients serviced through the state system in South Louisiana.

Quality care also is cost-effective. Woman's Hospital's costs and charges average 30-40% below regional and national averages and, according to Blue Cross of Louisiana data, are lower than other providers in the Baton Rouge area. The average reimbursement per adult discharge received from Medicaid at Woman's Hospital is less than \$1,500. By sharp contrast, the local charity hospital receives over \$7,000 per discharge from Medicaid as a result of disproportionate share payments. Cost-effectiveness in delivering care is directly related to economies of scale for high volume services. Approximately one-half of the cost of obstetrics care is in overhead-related expenses that remain virtually fixed regardless of the number of deliveries performed. Therefore, the first 25% of deliveries in any hospital are more expensive to perform than the last 25%, since those fixed costs are spread over higher volume.

Health care reform presents an opportunity for all Americans to have access to the quality, cost-effective care offered at specialty institutions such as Woman's. However, unless carefully designed, health care reform instead could undermine this ideal. For instance, under certain proposals, including the President's, health care reform would provide for the formation of government-certified health plans to serve all Americans. Unless mechanisms are established to assure that the role of specialty hospitals is preserved, and, indeed augmented, in these health plans, Woman's Hospital and others like it risk losing their base of high volume, routine services, which are necessary to sustain the quality, cost-effective routine and specialty services offered at our institutions.

In Louisiana, we are in the midst of a political battle that portends the future of health care delivery if health care reform is enacted without consideration of specialty providers. For example, the charity hospital facility in Baton Rouge, which was built the same year as Woman's Hospital, is in disrepair and requires renovation or replacement. The leading proposal to address this problem is to build a new facility at an approximate cost of \$48 million. Woman's Hospital is proposing to provide a full range of health care services, from primary care to the most sophisticated care, on a contract basis to the charity hospital system which would save \$17 million in construction costs alone. Woman's Hospital also has proposed to work with the state to ensure that a network of primary care outpatient clinics is in place so that all women in the geographic area served by Woman's and the charity hospital have access to necessary care. However, the state has indicated that it intends to build the new facility and not utilize the services of Woman's Hospital. This action would duplicate services already available at Woman's Hospital and could potentially redirect a significant percentage of Woman's patient base to the new facility. Yet, Woman's depends on this patient base for its financial viability and excellence of service. Indeed, high volume has proven to increase quality and improve cost-effectiveness. Fragmenting health care delivery in this manner is unwise.

The preliminary draft of the President's health care reform plan references the creation of a category of "designated specialty providers" and provides that states may establish requirements for health plans to assure access to services, including the requirement to reimburse or contract with designated specialty providers and centers of excellence. This is an encouraging statement. Our concern is that health care reform legislation provide adequate mechanisms to ensure that designated specialty providers are maximally utilized and remain viable, integral players in the health care delivery system. Any reform initiative must define "designated specialty providers" to include institutions such as Woman's Hospital that provide specialty care as well as primary and secondary services. Indeed, health plans should be required to contract with designated specialty providers for the entire range of health care services, from primary care to the most sophisticated, because without the high volume routine patient base, specialty hospitals would not be financially viable and could suffer in quality. Finally, in geographic areas with designated specialty providers, other providers should be required to formally demonstrate need before any new facilities could be built or beds designated for the services already provided by the designated specialty providers.

I would be pleased to answer any of your questions or provide you with additional information. Thank you.

Mr. KLECZKA. Dr. Balch.

STATEMENT OF CHARLES M. BALCH, M.D., VICE PRESIDENT AND CHIEF OPERATING OFFICER FOR HOSPITAL AND CLINIC, M.D. ANDERSON CANCER CENTER, HOUSTON, TEX.; ALSO ON BEHALF OF CITY OF HOPE NATIONAL MEDICAL CENTER, DUARTE, CALIF.; DANA-FARBER CANCER INSTITUTE, BOSTON, MASS.; FOX CHASE CANCER CENTER, PHILADELPHIA, PA.; FRED HUTCHINSON CANCER RESEARCH CENTER, SEATTLE, WASH.; ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH CENTER, COLUMBUS, OHIO; MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK, N.Y.; KENNETH NORRIS JR. CANCER HOSPITAL, LOS ANGELES, CALIF.; AND ROSWELL PARK CANCER INSTITUTE, BUFFALO, N.Y.

Dr. BALCH. Good afternoon, Mr. Chairman. I am Dr. Charles Balch, chief of surgery and vice president for hospital and clinics at the M.D. Anderson Cancer Center in Houston, Tex.

I am testifying on behalf of M.D. Anderson and the other eight freestanding cancer centers across the country. All of our institutions are designated as cancer centers by the National Cancer Institute. The mission of the cancer centers under the national cancer program, which was established by Congress, is to develop new treatments for cancer and introduce them into clinical practice. This has been an enormously successful program, and much of the progress made over the past two decades in cancer prevention, diagnosis and treatment is directly attributable to the work done in NCI-designated cancer centers.

We urge you to take care in reforming the health care system to protect both cancer patients and patients' right of access to these centers. The cancer centers are unique national resources in the continuing effort to develop effective treatments for cancer, including prevention, and they must remain capable of fulfilling their mission.

We have three principal recommendations to carry out these objectives: First, cancer patients enrolled in managed care plans must be guaranteed the right to receive treatment at an NCI-designated cancer center at the same cost to the patient as for any network providers. The state-of-the-art treatments available at the cancer centers should not be limited just to the wealthy but should be available to all Americans.

The provisions in the President's proposal related to access to academic health centers and to designated specialty providers should be broadened to include these cancer centers. Moreover, access should be guaranteed regardless of the patient's state of residence.

These cancer centers are true national resources for all Americans. For example, 40 percent of M.D. Anderson's patients come from outside of Texas, 35 percent of patients from the Memorial Sloan-Kettering Cancer Center come from outside of New York, and 75 percent of patients from the Fred Hutchinson Cancer Center in Seattle come from out of their State.

Second, we strongly endorse the President's proposal to include coverage of patient care in approved clinical trials in the guaran-

teed national benefits program. The entire Nation would benefit because these trials produce the great medical improvements that we continually seek in our battle against cancer. Patients in clinical trials would benefit because they would receive treatments that may be substantially more effective and in many instances less expensive compared to conventional treatment. Coverage of patient care costs in approved clinical trials as part of the basic benefits package would be a major step toward assuring the highest quality care for cancer patients as well as supporting the development of new therapies that represent the future standard cancer care for our children.

Finally, the special nature of the cancer centers must be taken into account in designing payment mechanisms. Cancer centers treat a disproportionate number of severely ill patients and use particularly sophisticated techniques. As a result, it would not be appropriate to pay cancer centers in the same way as community hospitals that provide less intensive treatments and refer their more complicated patients to us.

Therefore, there should be a percentage add-on payment to cover the extra costs incurred by the NCI-designated cancer centers in carrying out their duties under the national cancer program. This would be similar to the payment for academic health centers proposed by the President's plan.

Also, a special payment methodology for the 93 cancer centers such as the method already established under the Medicare system should be carried over to any rate setting by the States or health alliances.

In summary, Mr. Chairman, I urge the committee to develop a health care proposal that guarantees all cancer patients the right to the best treatment available and that ensures that the NCI-designated cancer centers will continue to provide this cancer treatment.

Thank you for the opportunity of presenting to you.

Mr. KLECZKA. Thank you, Dr. Balch.

[The prepared statement follows:]

STATEMENT OF CHARLES M. BALCH, M.D.
Vice President and Chief Operating Officer
for Hospital and Clinic, M.D. Anderson Cancer Center

submitted on behalf of

M.D. ANDERSON CANCER CENTER, Houston, TX
CITY OF HOPE NATIONAL MEDICAL CENTER, Duarte, CA
DANA-FARBER CANCER INSTITUTE, Boston, MA
FOX CHASE CANCER CENTER, Philadelphia, PA
FRED HUTCHINSON CANCER RESEARCH CENTER, Seattle, WA
ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH CENTER, Columbus, OH
MEMORIAL SLOAN-KETTERING CANCER CENTER, New York, NY
KENNETH NORRIS JR. CANCER HOSPITAL, Los Angeles, CA
ROSWELL PARK CANCER INSTITUTE, Buffalo, NY

**ASSURING PATIENTS GUARANTEED ACCESS TO THE CANCER CENTERS
IN A REFORMED HEALTH CARE SYSTEM**

The National Cancer Program was enacted by Congress in 1971 to improve the prevention, diagnosis, and treatment of cancer. An important element of the program is the designation by the National Cancer Institute (NCI) of comprehensive and clinical cancer centers.

The NCI-designated cancer centers are the cornerstones for deepening the understanding of the causes and cures for cancer, for applying this knowledge to patients under treatment, and for disseminating this knowledge to community hospitals. The cancer centers have developed many of the major advances in cancer treatment.

The role of these national resources -- and the continued success of the National Cancer Program -- may be threatened by health care reform unless their special mission is taken into account:

- Patients in managed care programs must be guaranteed access to the NCI-designated cancer centers.

Cancer patients must be permitted to choose treatment at an NCI-designated cancer center without extra financial obligation. Otherwise, the cancer centers could be available only to affluent patients.

In addition, NCI-designated cancer centers should be automatically treated as designated specialty providers to which managed care plans must allow the referral of their enrollees.

- The basic benefits package must cover treatment of cancer patients in qualified clinical trials that substitutes for standard, and possibly less effective, therapy.

The customary exclusion of "investigational" services must not extend to qualified clinical trials involving cancer patients, since the reasons for the exclusion do not apply to such trials.

- Any cost controls or payment mechanisms must be designed to accommodate the atypical services and patients of these cancer centers.

The cancer centers treat a disproportionate number of severely ill patients and use particularly sophisticated techniques. Their extra costs should be recognized in a percentage add-on payment analogous to the proposed add-on for academic health centers.

Also, current law affords nine freestanding cancer centers special status under the Medicare reimbursement system because of their atypical services and patients. Comparable status for both inpatient and outpatient services should be afforded the nine centers under any payment mechanisms adopted by states or health alliances.

The Cancer Centers Are National Resources

As part of the National Cancer Program, the NCI was directed to designate certain cancer centers to develop new treatments for cancer and introduce them into clinical practice.^{1/} These state-of-the-art therapies and research activities offer the greatest possibility for successful treatment of cancer patients. Moreover, research is the driving force that allows these cancer centers to develop innovations that replace less effective cancer treatments and provide a positive impact on both the quality of life for cancer patients and the cost of treatment.

As the centers develop new methods for treating, preventing, and detecting cancer, they demonstrate their effectiveness through treatment of patients at the centers and disseminate information on these developments so that they can be incorporated into clinical practice throughout the country. Much of the progress made in understanding the biology of cancer and the treatment of this disease is directly attributable to the work done in these NCI-designated cancer centers.

The cancer centers have played pivotal roles in developing and advancing treatments for childhood leukemias which previously were often fatal and are now highly curable; safely substituting lumpectomy for mastectomy in many breast cancer patients; developing techniques for the early detection of cancer; originating limb preservation techniques that minimize disability and disfigurement; developing bone marrow transplantation to cure previously untreatable cancers; and perfecting ambulatory cancer treatment for large numbers of patients. The work continues, as the cancer centers innovate in such areas as gene therapy and immunotherapy. The cancer centers' endeavors have contributed to the increasing number of survivable cancers and have enabled countless individuals to return to productive lives.

Health care reform must be undertaken in a manner that does not undermine the National Cancer Program nor deprive patients of access to these cancer centers.

Assuring Access to the Cancer Centers

Many health care reform proposals, including the President's, are intended to foster the development of managed care. In any expansion of managed care, extreme care must be taken to assure that cancer patients are not denied the state-of-the-art treatment available primarily, and often only, at the NCI-designated cancer centers. These federally designated national resources must continue to be available to the general population and should not be limited to affluent patients who can afford high coinsurance payments or special insurance coverage.

Moreover, without a patient base with which to test promising new techniques, the essential translation of treatment advances from laboratory bench to the patient's bedside will not occur. Without patients, the cancer centers would be unable to carry out their mission under the National Cancer Program.

1/ 42 U.S.C. §§ 285a through 285a-3.

Therefore, any health care reform legislation must contain the following protections to assure access by cancer patients to the NCI-designated cancer centers --

- Any cancer patient enrolled in a managed care plan would be guaranteed the right to choose treatment at an NCI-designated cancer center. Managed care plans would be required to arrange for such treatment at the same cost to the patient as for in-network services.
- Managed care plans would be required to provide information on NCI-designated cancer centers to plan enrollees.

In addition, the President's proposal should be modified as follows --

- Health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence. This should be a state mandate -- not a state option, as the President's plan would apparently provide.
- NCI-designated cancer centers should automatically be considered to be designated specialty providers or centers of excellence.
- Although the regional health alliances would be organized on a state basis, the mandatory referral to NCI-designated cancer centers should not be limited to in-state centers. Health plans should be required to permit the referral of their patients to an NCI-designated cancer center that can provide appropriate services regardless of location.

The Basic Benefits Package Should Cover Qualified Clinical Trials

A clinical trial on a new cancer therapy is initiated because of the belief, based on preliminary evidence, that the therapy is likely to be more effective than the conventional therapy otherwise available. The trial is intended to establish the superiority of the new therapy definitively. Patients in trials benefit since they receive treatment that may be substantially better than conventional treatment and that, in any event, is not likely to be less effective.

The NCI-designated cancer centers play a major role in conducting clinical trials of new methods to prevent and treat cancer. Through such trials, the cancer centers develop the standards of treatment that are eventually used by physicians and institutions throughout the country. The system of NCI-designated cancer centers is a model structure for determining which treatments are effective.

Although clinical trials offer the possibility of superior treatment for cancer patients, insurers frequently deny coverage of the associated medical care, such as the hospital stay or physician visits, under policy or plan provisions excluding "investigational" or "experimental" treatment. By inappropriately invoking provisions designed to prevent payment for questionable or speculative treatments, insurers have adopted policies precluding reimbursement for state-of-the-art, advanced medical treatments that are frequently more effective and ultimately more cost-effective than those the insurers would readily pay for.

The National Cancer Institute agrees that health insurance should cover clinical trials --

"NCI does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered.... For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."^{2/}

The basic benefits package established in health care reform legislation must include coverage of the medical care associated with clinical trials provided to cancer patients if the trials have been approved by (1) NCI or an NCI-designated cancer center, cooperative group, or community clinical oncology program; (2) the Food and Drug Administration, in the form of an investigational new drug exemption (IND); (3) the Department of Veterans Affairs; or (4) a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants.

Coverage of cancer clinical trials should not increase aggregate health care costs. Treatment of cancer patients through clinical trials is ordinarily a substitute therapy that is not necessarily more expensive than conventional therapy.

The President's proposal would include the "routine costs" of approved clinical trials in the guaranteed national benefits package. The scope of routine costs is unclear at this time. While we would not expect administrative costs of the clinical trials to be covered, all patient care costs should be covered.

There Should Be a Special Payment Mechanism To Finance the Statutory Duties of the Cancer Centers

To carry out their mission under the National Cancer Program, the NCI-designated cancer centers treat a disproportionate number of severely ill patients, and they utilize sophisticated, state-of-the-art methods. The centers are mandated under the National Cancer Program to help find a cure for cancer. This function cannot be accomplished without the development of new technology, and payment restrictions that act to suppress new technologies at the centers would be contrary to their statutory function. The centers cannot fulfill their mission if they are paid on the same basis as community hospitals that treat an ordinary patient population with standard forms of treatment.

To compensate for the extra costs associated with their functions under the National Cancer Program, the NCI-designated cancer centers should receive a percentage add-on payment similar to the payment proposed by the President for academic health centers. Just as the add-on for academic health centers would

2/ Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." January 1989. (Submitted to the Senate Committee on Appropriations in response to S. Rep. No. 100-399.)

finance the recognized value of these institutions' research and training efforts, a similar payment to the NCI-designated cancer centers would permit them to carry on their analogous functions.

**The Nine Freestanding Cancer Centers Should Be
Protected From Inappropriate Payment Methodologies**

Although most of the NCI-designated cancer centers are part of larger, diversified institutions, nine of them are renowned freestanding facilities.^{3/} As such, they are particularly vulnerable to any health care financing measures that do not take their unique characteristics into account. For that reason, Congress determined that the Medicare diagnosis-related group (DRG) system was inappropriate for the nine centers.

By law, Medicare exempts the nine centers from the prospective payment system (PPS) for inpatient hospital services and instead pays them under a cost-reimbursement method.^{4/} Since PPS uses DRGs based on typical cases, Congress concluded that it would not be appropriate for the atypical services of, and patients treated by, the nine cancer centers.

In a June 1993 report, the Prospective Payment Assessment Commission (ProPAC) reconfirmed that the reasons for the statutory exemption continue to exist today.^{5/} The statutory exemption acknowledges the cancer centers' status as unique, state-of-the-art facilities with the most acutely ill cancer patient populations. Importantly, the exemption confirms that the existing cancer DRGs do not reflect the complexity of illnesses treated at the cancer centers, or the intensity of services provided.

If health care reform legislation allows or requires rate-setting, it should include special requirements governing the nine freestanding cancer centers comparable to the Medicare exemption. For example, under the President's proposal, the regional alliances would issue fee schedules for the fee-for-service health plans, and states could regulate payments under health plans to assist the health alliances in meeting the federally required premium targets.

As Congress recognized in exempting the nine freestanding centers from the Medicare prospective payment system, controls based on average cases or the experience of ordinary institutions, such as controls based on DRGs, would be completely inappropriate for these freestanding centers. Federal legislation should require a similar approach, with respect to both inpatient and outpatient services, for any rate-setting by states or regional alliances.

3/ The nine are: M.D. Anderson Cancer Center, Houston, Texas; City of Hope National Medical Center, Duarte, California; Dana-Farber Cancer Institute, Boston, Massachusetts; Fox Chase Cancer Center, Philadelphia, Pennsylvania; Fred Hutchinson Cancer Research Center, Seattle, Washington; Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio; Memorial Sloan-Kettering Cancer Center, New York, New York; Kenneth Norris Jr. Cancer Hospital, Los Angeles, California; Roswell Park Cancer Institute, Buffalo, New York.

4/ 42 U.S.C. § 1395ww(d)(1)(B)(v).

5/ Prospective Payment Assessment Commission. "Medicare and the American Health Care System: Report to the Congress." June 1993. Pages 84-85.

An appropriate rate-setting methodology would be based on the historical costs (e.g., average-per-patient costs) of each freestanding cancer center, updated to reflect inflation and any significant changes in the center's patient case-mix or services provided. Any such methodology should be subject to revision based on changes at each center. Rates must be established in a manner such as this if the nine freestanding cancer centers are to remain viable.

Alternative State Systems

Some proposed health care reform plans would allow states to substitute their own reform and cost control plans for the national program. If this is permitted, the federal legislation should require states to adopt the protections and benefits package requirements specified above. The National Cancer Program is an important federal initiative that should not be thwarted by state regulation that does not adequately accommodate the NCI-designated cancer centers.

Summary

To ensure that the services of the NCI-designated cancer centers remain available to patients, and that these centers continue to provide complex, state-of-the-art treatment, it is essential that health care reform be structured to include the following elements:

- Patients in managed care plans suffering from cancer must be guaranteed access to the specialty services and treatment available at the NCI-designated cancer centers without the financial penalties assigned to out-of-network care.
- All managed care plans should be required to provide information on NCI-designated cancer centers, and how to access their services, to their enrollees.
- In the President's plan, NCI-designated cancer centers, including out-of-state centers, should be included as "designated specialty providers" to which health plans must allow the referral of their enrollees.
- Qualified clinical trials must be included in the basic benefits package.
- There should be a percentage add-on payment to cover the costs incurred by the NCI-designated cancer centers in fulfilling their responsibilities under the National Cancer Program.
- Rate-setting applicable to the nine freestanding cancer centers should be limited to an appropriate non-DRG methodology for both inpatient and outpatient services.
- Any alternative state systems created under the health care reform legislation should be required to include comparable protections for the cancer centers and patients.

Mr. KLECZKA. Mr. Lewis Molnar, executive vice president Shriners Hospital.

STATEMENT OF LEWIS K. MOLNAR, EXECUTIVE VICE PRESIDENT, SHRINERS HOSPITALS FOR CRIPPLED CHILDREN

Mr. MOLNAR. Mr. Chairman, members of the subcommittee, I am Lewis Molnar, executive vice president of Shriners Hospitals headquartered in Tampa, Fla.

First, I would like to express my appreciation for this opportunity. I am not certain that everyone here is aware of the role we play in providing care and services to children. We treat children with problems of the bones, joints and muscles at our 19 pediatric orthopedic facilities and children who are burned at our three world-renowned Shriners institutes.

The only criteria for admission to Shriners Hospitals are medical necessity and financial need. We treat children from every State, and we operate clinics in Puerto Rico and the U.S. Pacific Trust Territories. All services at Shriners Hospitals are provided totally free of charge, and we do not accept State or Federal funds, nor do we accept any insurance or third party payments.

To our knowledge, Shriners Hospitals makes the largest contribution to the care of disabled children on a continuing basis. Our operating budgets have exceeded the entire Federal contribution to title V State children's programs in each of the last 5 years. For 70 years, Shriners Hospitals have made and continues to make significant contributions to the health care of the Nation's children.

In a reformed health care system, Shriners Hospitals can continue to play a vital role. The continuing ability of Shriners Hospitals to provide quality, efficient health care, using charitable funds, will depend to a great extent on our continuing freedom from burdensome Federal regulations and provider taxes which could dramatically increase our costs of providing this care.

Despite the enactment of title V of the Social Security Act and the advent of the Medicaid program, there are still large numbers of children who are unable to access high-quality tertiary care services except through Shriners Hospitals. We suspect that this need will continue even in the event of major health reform.

During 1992, Shriners Hospitals accepted 27,477 new patients, performed 18,500 operations, and provided over 200,000 outpatient visits to children in need.

We were delighted to hear Mrs. Clinton's response to Congressman Neal's question during her recent testimony before the Ways and Means Committee. His question was if she would ensure that health care reform does nothing to damage the charitable work Shriners Hospitals is doing. Her response was that she believed Shriners Hospitals to be a part of the system that is not broken, and, therefore, we ought not try to fix it.

Our written statement contains several specific recommendations which we believe should be included in any health care legislation. We would appreciate your assistance in facilitating dialog between Shriners Hospitals and Federal planning groups or agencies so that meaningful relationships and collaborations can be developed.

Thank you for allowing us to express our views.

Mr. KLECZKA. Thank you, Mr. Molnar.

[The prepared statement follows:]

STATEMENT
OF
SHRINERS HOSPITALS FOR CRIPPLED CHILDREN

Mr. Chairman and members of the Sub-Committee, I am Lewis K. Molnar, Executive Vice President of Shriners Hospitals for Crippled Children (SHCC) headquartered in Tampa, Florida.

Shriners Hospitals appreciates the opportunity to comment before the Sub-Committee on its current and future role in the delivery of charitable health care services to the nation's children.

Shriners Hospitals shares the goal of the Congress and the American people of having universal access to health care services for all Americans and wishes to coordinate access to its highly specialized tertiary care services with the developing new health care delivery system.

In our testimony today, we wish to make the following points:

1. For over 70 years Shriners Hospitals has made, and continues to make, significant contributions to the health care of the nation's children.
2. In a reformed health care system, Shriners Hospitals can continue to play a vital role in the provision of highly specialized, totally free, tertiary health care services for children.
3. The continuing ability of Shriners Hospitals to provide quality, efficient health care using charitable funds will depend to a great extent on our continuing freedom from burdensome federal regulations and provider taxes which could dramatically increase our costs of providing care.

1. Contributions of Shriners Hospitals to Children's Health Care

Founded as a wholly charitable corporation in 1922, Shriners Hospitals for Crippled Children (SHCC) today owns and operates 22 pediatric hospitals in North America, which focus on the care of orthopaedically handicapped and burned children. The 19 pediatric orthopaedic hospitals and 3 burn institutes contain over 1,000 beds and are totally dedicated to the provision of high quality, free care to children with musculoskeletal disabilities and burn injuries. With the exception of two orthopaedic hospitals, located in Montreal and Mexico City, all Shriners Hospitals are within the United States.

The original charter of SHCC specifically prohibits acceptance of any payment for services rendered in Shriners Hospitals. No patient, family, government or third party payment is ever sought or accepted for care given in our institutions. The only criteria for admission to SHCC are medical necessity and financial hardship. All care is financed by voluntary contributions from the general public and the nearly 700,000 Shriners. Over 2.25 billion dollars has been expended to date in the provision of health care to children. In 1993, 96% of Shriners Hospitals' operating budget will be spent on patient care and research.

To our knowledge, Shriners Hospitals makes the largest single contribution to the care of disabled children in the United States on a continuing basis. The annual operating budget of Shriners Hospitals (\$290 million for 1993) has exceeded the entire federal contribution to the Children With Special Health Care Needs (CHSCN) Title V state programs in each of the last five years.

During 1992, SHCC accepted 27,477 new patients, hospitalized over 21,000 children for care, performed 18,500 operations and provided over 200,000 outpatient visits to children in need.

The mission of Shriners Hospitals has always been to provide optimum, compassionate care for special categories of childhood illnesses free of charge. Recognition of the need for specialized hospitals for the treatment of children with polio and other crippling diseases prompted the founding of Shriners Hospitals in 1922. In the 1960's, the need to properly care for severely burned children was identified and the three Shrine Burn Institutes were created. In the 1980's, the need for specialized pediatric spinal cord injury care was identified and centers for the care of these children were developed at three of our orthopaedic hospitals. From time-to-time other special health care needs of children are assessed and new programs are initiated.

Common childhood disabilities treated by SHCC include cerebral palsy, spina bifida, congenital absence of limbs, spinal deformities, congenital and acquired limb deformities and inequalities, diseases of the bone and joints and burn injuries. Spinal cord injured children are cared for at regional centers located in our Philadelphia, Chicago and San Francisco hospitals. Comprehensive programs for care of children with cleft lip and palate are located at our Chicago, Portland, Cincinnati and Galveston hospitals.

SHCC also allocates \$20 million annually in support of a basic research program directed toward discovering the cause of crippling diseases and improving the clinical management of such children, including those suffering from burn injuries. The large number of scientific publications which continually emanate from SHCC research programs has significantly improved the treatment of children worldwide. Shrine researchers have received national and international recognition for the excellence of their work on many occasions.

All Shriners Hospitals are affiliated with major medical centers and teaching institutions. Over two hundred resident physicians and surgeons receive training in pediatric orthopaedics and burn care annually at SHCC.

Despite the enactment of Title V of the Social Security Act in 1935 and the advent of the Medicaid program in 1967, there are still large numbers of children today who are unable to access needed high quality tertiary care services except through Shriners Hospitals. We suspect that this need will continue even in the event of major health reform.

2. The Role of Shriners Hospitals in a Reformed Health Care System.

In a reformed health care system which provides universal access to care, Shriners Hospitals wishes to continue to be a major contributor to the health care needs of the nation's children through the provision of timely, high quality, tertiary health care services. We appreciate the current need to augment primary health care services for children, but we also realize that it is likely that the extensive use of primary care providers as "gate-keepers" may limit access to more expensive specialty and tertiary health care. We believe that it is important that equal and timely access to advanced tertiary care, such as Shriners Hospitals provides, continue to be made available to those children who need them.

Prompt access to high quality care for burned children and spinal cord injured children is enormously more cost effective than caring for major complications in such children caused by delay in treatment or inadequate initial care. Similarly, delay in treating progressive orthopaedic deformities adds significantly to the cost of care. In the long run, poor outcomes of handicapping conditions in childhood which could have been prevented by early access to quality tertiary care can result in a lifelong dependence on social services and programs at a tremendous cost to society as a whole.

We are concerned that under a gate-keeper system, wealthier families who can afford additional insurance will have unrestricted access to this type of care but that for many children whose families are of lesser means, free and timely access to highly specialized services such as Shriners Hospitals offers may remain elusive. This, apparently, is also the opinion of the Congressional Budget office, which, in a major study of a managed competition, concluded in May, 1993, that consumers will probably have less choice, more limited access to many providers, fewer services and slower access to new technologies.

Our experience to date in areas of the country which have strong managed health care programs also confirms this assumption. Shriners Hospitals located in these areas even now serve many severely handicapped and burned children who are enrolled in managed care plans when either the cost of care or the lack of expertise results in their being excluded from benefits. In fact, Shriners Hospitals have always supplemented and complemented other private and public health programs offering care for categories of children which it serves. We believe strongly that the best and most cost effective health care reform will occur with successful collaborations between the public and private sectors which capitalize upon the strengths of both.

For example, for the past three years SHCC and the CHSCN programs of five states have been involved in a demonstration project to validate the benefits to patient care of supplementing and coordinating their respective resources in case management. This project, known as CHOICES¹, is funded by the Bureau of Maternal and Child Health through the Kentucky Commission for Handicapped Children with matching resources from SHCC. The project has involved our hospitals in Cincinnati, Ohio; Lexington, Kentucky; and Greenville, South Carolina and the states of Ohio, Kentucky, South Carolina, West Virginia and Tennessee. Dual enrollment of children in the SHCC and CHSCN state programs has resulted in better coordination of services, better case management, the elimination of duplicated services and higher patient and family satisfaction. The project will soon be replicated in other areas of the country through systematic collaborations between other Shriners Hospitals and other state agencies. In such a system, the Shriners Hospital serves as the tertiary care center, or hub of the wheel, and the CHSCN programs serve as the spokes, or the day-to-day care providers with communication regarding case management flowing in both directions.

We believe this model could well work with other managed care systems, and for the future we intend to explore collaborative arrangements of this kind with health provider networks. By so doing, we hope to insure access to our resources for children who need them and, from the standpoint of Shriners Hospitals, to acquire better community-based care for our own orthopaedic and burn injured patients.

An essential feature of the managed competition health care model and of those legislative proposals before the Congress which incorporate this model, is the accountability of health care entities to the public and to the purchasers of health care through the reporting of patient outcome data. Collectively, over time, and at any given time, Shriners Hospitals has the largest experience in treating pediatric orthopaedic and burn pathology of any institution in the United States, and perhaps the world. The outcome data which we would be able to provide, given a multi-institutional patient data management system, could be extremely valuable in determining practice guidelines for much of the

¹CHOICES: Children's Healthcare Options Improved Through Collaborative Efforts and Services

pediatric orthopaedic and burn care in the United States. To that end, Shriners Hospitals has an initiative in progress to develop a program of outcomes management based upon the acquisition and aggregation of multi-institutional patient data from our hospital system. Initially, we will be doing retrospective long-term analyses of outcomes and large patient populations of significance. As a long-term goal, we are developing the capability for an electronic medical record for the aggregation and analysis of system-wide patient data.

Finally, Shriners Hospitals plans to continue to fund basic research efforts at its six major research centers. Burned and orthopaedically handicapped children the world over have benefited from the results of SHCC research. Examples include, the development of cultured skin and artificial skin for burned patients, the development of a nutritional formula widely used for acutely burned children, the use of growth hormone to improve healing rates in burned children, new methods of treatment for children with metabolic bone disease and the discovery of certain new collagen molecules and the genetic basis for Marfan's syndrome, the disease which affected President Lincoln.

3. Preserving the Ability of Shriners Hospitals to Contribute to Children's Health Care in the Future.

Because Shriners Hospitals neither seeks nor accepts any form of payment for the services which it renders, including payments from third party carriers and government agencies, we have been exempt from the myriad of cost containment regulations imposed by the payers of health care. There are no cash registers in Shriners Hospitals, no insurance offices and no billing and collection functions. While we are most conscience of cost effective care, we have no restrictions such as pre-admission criteria or conditions or restrictions on length of stay.

On the other hand, our hospitals are extremely quality-conscience and our quality management programs are excellent. All of our hospitals are accredited by the Joint Commission on Accreditation for Health Care Organizations. Last year, seven of our hospitals were surveyed by Joint Commission on Accreditation for Health Care Organizations. All were accredited and four of the seven received accreditation with commendation.

However, a major reason for the ability of Shriners Hospitals to make effective use of its charitable funds, to be able to provide cost effective, as well as cost efficient care and to be able to support major research programs, is that we do not have to employ an infrastructure to deal with burdensome regulations imposed by payers of health care. Further, in states which have enacted provider tax legislation, we have been successful in obtaining exemption from such taxes.

To avoid any unintended adverse effects to our charitable institution and its programs, Shriners Hospitals for Crippled Children suggest that the following provisions be included in any health care reform legislation adopted by the United States Congress:

1. A definition of "charitable provider" in terms such as "a provider which furnishes medical and/or surgical care wholly free of charge to its patients, and which neither seeks nor accepts direct or indirect governmental aid or insurance company reimbursements".
2. A provision (in addition to § 501(c)(3) of the Internal Revenue Code) which specifically excludes "charitable providers" from the imposition of any taxes levied to support health care reform.

3. Provisions which specifically exclude "charitable providers" from regulatory provisions (other than those which are directly related to patient safety) which are enacted as a part of health care reform.
4. Provisions allowing other institutions, including governmental agencies, to cooperate with "charitable providers" in collaborative care for the benefit of their patients; and specific provisions to the effect that, by engaging in such collaborative care, "charitable providers" will not be considered to have sought or accepted direct or indirect government aid.

Finally, we would appreciate your assistance in facilitating dialogue between SHCC and federal planning groups or agencies so that meaningful relationships and collaborations can be developed between Shriners Hospitals and health care provider networks in a reformed health care system.

We appreciate the opportunity to express our views concerning the continuing role of our charitable institution in the provision of children's health care services in a reformed health care system which provides for universal access of care to all Americans.

Mr. KLECZKA. John Forsman, chief financial officer from the Community Medical Center in Toms River, N.J..

STATEMENT OF JOHN A. FORSMAN, SENIOR VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, COMMUNITY MEDICAL CENTER, TOMS RIVER, N.J.

Mr. FORSMAN. Thank you.

If I could just have a moment, we are setting up a few maps here to help with my testimony. We also have a few additional comments, in addition to the report we turned in previously, that we would like to have turned in as an addition to our testimony that we have here today.

Mr. KLECZKA. Fine. That will be made part of the record also.

Mr. FORSMAN. Yes, this should be made part of the record. Thank you.

Good morning, Mr. Chairman, members of the committee. I would first like to thank you for the opportunity to appear today. We would like to give you some of our experience on how the Medicare system is working and also give you some ideas on how we think Medicare can most effectively be fit in with health care reform. Most of what I have to say may be considered different from people in my position—in fact, heresy among some of my peers—so if you just care to listen.

I would, first, like to—I am the chief financial officer at the Community Medical Center in Toms River, N.J. I am also the chairman of the board of the Association of High Medicare Hospitals. Community Medical is a 600-bed acute care facility with a 75 percent patient load attributable to the Medicare program.

The difference in the Medicare payments that now exist from one region to another are, as Mrs. Clinton recently stated, very difficult to justify. Currently, too many special programs and adjustments have been developed to protect special interests and certain localities. This has resulted in ambiguous incentives, enormous inequities and a constant scrambling for turf protection.

It is the initial—the inequities we are talking about in particular are shown on the map. One map shows average cost per case for each State compared to the national case-mix, wage-adjusted average of about \$4,500 a case. States shown in red on this map have high costs compared to the average, white are at the average, and blue depict low-cost States. The other map shows how States compare on a profit and loss basis under the federally mandated PPS.

I would suggest that if the PPS were working in a fair and equitable manner, high-cost States would be losing money, low cost making money, and so forth.

However, unfortunately, this is not the case. In fact, one high-cost State, New York, which shows as red on the one map, appears blue on the other. They are actually high cost and making profits. Many other average cost States, especially highlighted in the southeast region from the Carolinas across to Louisiana, have relatively low costs or moderate costs. You can see they show as red, losing money under the program. This unfair, inequitable distribution of Medicare budgets puts some States in a much better position than others as we enter the era of health care reform.

States with an advantage currently under the Medicare program are much better able to bargain with regional health alliances because they do not carry the Medicare burden that States like mine must deal with. I believe you cannot have true health care reform without a level playing field for the largest payer, meaning Medicare.

The data my staff utilized to prepare these maps is based on 1990 information. We have contracted with, consulted with, Lewin-VHI to do the same analysis for 1991. The results, when completed, were pretty much identical to our own.

We have developed a proposal to address these problems on this map. This is where the heresy comes in. Our proposal's main objective is to reward efficient facilities while penalizing those with high costs. We may be able to accomplish this by establishing a standard rate for each State based on that State's average cost. Hospitals with costs above this wage- and case-mix adjusted standard would be penalized. Hospitals that cost below that standard would receive an incentive, as it were, for keeping the costs down. We worked with Lewin-VHI to model the incentive amounts for each hospital in every State.

We think you will be amazed at the amount of money the Medicare program can save by adopting our proposal. Again more heresy, the best feature of our savings comes just from the high costs we moved from high-cost facilities. That is where the savings will come from. Low-cost facilities will be recognized for their record and granted incentives.

We do not propose to abandon GME, IME or DSH portion of share payments. We believe we have a sensible plan to transition them under health care reform.

It is also important to remember the High Medicare Hospitals. As I mentioned earlier on, I am the chairman of the board of that group, and these hospitals, by necessity, have become some of the lowest-cost facilities in the country. They are typical of the kind of hospitals that we talk about earlier. They responded, in a sense, to PPS.

As I pointed out, they are suffering under the program. They are the ones receiving the greatest losses under the program.

I would like to thank you for the opportunity to be here today and also pass on that we have shared our proposals with ProPAC and HCFA. We would like the opportunity to further meet with them as well as members of this committee to go through some of our proposals which I think are directly in sync with health care reform.

Mr. KLECZKA. Thank you for your testimony.

[The prepared statement and subsequent submission follow:]

STATEMENT OF JOHN A. FORSMAN
SENIOR VICE PRESIDENT AND CHIEF FINANCIAL OFFICER
COMMUNITY MEDICAL CENTER
BEFORE THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Mr. Chairman and Members of the Subcommittee:

I am John Forsman of the Community Medical Center (CMC). I would first like to thank you for the opportunity to appear before you this morning. I would like to share our ideas on how the Medicare program can be included most effectively in comprehensive health care reform and how Medicare's experience in hospital payment can be used to the benefit of the entire health care system.

I am the Chief Financial Officer at CMC, which is a 600-bed acute care facility in Ocean County, New Jersey. I am also the current Chairman of the Board of the Association of High Medicare Hospitals and have been a board member of the Health Care Financial Management Association. Community Medical Center has the distinction of serving more Medicare patients than any other single facility in our state. I believe there are very few facilities in the entire country with as great a Medicare population as Community Medical Center. In fact, 75% of our patient days are attributable to Medicare patients. Thus, we feel it is imperative to consider Medicare very closely during the debate on health care reform.

Recently, I was reading Mrs. Clinton's comments before the Ways and Means Committee regarding Medicare payments. As an administrator with almost 20 years of experience, I can report to you that she was right on track. The differences in Medicare payments that now exist from one region to another are, as Mrs. Clinton stated, "difficult to justify." Too many special programs or adjustments have been developed to protect localities or special interests. This has resulted in ambiguous incentives and a constant scrambling for turf protection.

Over the past 6 years a smaller percentage of the Medicare budget has been spent on direct patient care, while a dramatically increasing percentage is going toward other targeted objectives. This is demonstrated on the following schedule prepared by Lewin-VHI, which shows less of the budget going toward the care of the elderly in basic DRG and outlier payments and large increases in the IME (indirect medical education) and DSH (disproportionate share payments).

Distribution PPS Operating Payments by Payment Type
in Percent for Fiscal Years 1988-1993
Prepared by Lewin-VHI

All Hospitals			
<u>PPS Operating Payments</u>	<u>1988</u>	<u>1993</u>	<u>Total Percent Change</u>
Basic DRG	88.0%	85.9%	-2.4%
Outlier	5.7%	4.3%	-24.6%
IME	4.2%	5.6%	33.3%
DSH	2.1%	4.1%	95.2%

Medical education and disproportionate share (uncompensated care) are important social needs. However, the Medicare program was established for the care of the elderly. Its viability should no longer be compromised to solve these other difficult social problems. Moreover, the need for disproportionate share adjustments will be addressed by universal coverage, as the Administration's proposal to phase out this adjustment recognizes.

Ocean County has 5 acute care hospitals, with 2 of the 5 under the same ownership. Therefore we have 4 separate systems. All 4 serve a disproportionately high percentage of Medicare patients. All have at least a 65% Medicare population. We have not been able to find any other single county in the nation with all high Medicare hospitals, even in Florida and Arizona. We are an area that has not fared well under the Medicare program, even though our neighbors to the north, New York City, and our neighbors to the west, Philadelphia, have done much better. The differences would be understandable if our costs were higher than our neighbors'. However, this is not the case. The cost per case for all Ocean County hospitals is at or below the national average. We are all among the most efficient (lowest cost per case) of any facilities in our state. We are doing poorly under Medicare because we don't have any special "add-ons," and the Medicare wage index, as it now exists, rewards high-cost areas by sanctioning and reimbursing their costs.

As the system now functions, there is no independent review to ascertain if the wages paid in contiguous regions are reasonable. For example, the wage index in effect in New York City as of the first of this month is approximately 1.4. The index for my area, Monmouth/Ocean County, now stands at about 1.0. Therefore, the system has decided that salaries about 60 miles to the north of my region require a 40% payment differential. This is based on cost report data as reported by all hospitals in the nation. I have lived in New Jersey my entire life. I know people who commute to work in New York City. I can assure you the 40% differential is exaggerated.

I would not expect you to take these comments at face value. Therefore, we have gathered a sample of 1992 salary and wage data as published by the United States Department of Labor. We have done comparisons for several different job categories for various positions in New York City as opposed to the Monmouth/Ocean County area. As you will see below, the normal differential falls anywhere in the 10%-15% range. The 40% differential cannot be reasonably justified.

Occupational Compensation Survey -- Monmouth/Ocean, New Jersey vs. NY, New York

Source: U.S. Department of Labor Bureau of Labor Statistics, 1992 data

	<u>Weekly Earnings</u>		
	<u>Monmouth/Ocean, NJ</u>	<u>NY, New York</u>	<u>% Variance</u>
	MEAN	MEAN	MEAN
<u>Computer Programmers</u>			
Level II	554	622	12.27%
<u>Computer Operators</u>			
Service Producing	441	476	7.94%
<u>Clerks, General</u>			
Level II - Service Producing	305	350	14.75%
<u>Secretaries</u>			
Level I	402	421	4.73%
<u>Switchbd. Op./Receptionist</u>			
Service Producing	349	390	11.75%
<u>General Maintenance</u>			
Service Producing	12.25	13.15	7.35%
<u>Janitors</u>	9.85	11.52	16.95%

Cost report data may add up to the 40% difference when adjusted and massaged. However, the system needs to build in safeguards, as I have described, and then appropriately challenge unreasonable variances such as those on this chart. Unless current policies are amended, there will not be enough dollars in the Medicare budget to fairly pay "plain vanilla" acute care hospitals. It is frequently said that under the prospective payment system (PPS) all institutions

are paid utilizing the same rules and the same rates. My experiences have taught me that this is not the case.

I have been traveling to Washington, D.C. several times a year for the past 6 years to try to get the Medicare system to restore equity, fairness, prospectivity and incentives for reducing costs. In my opinion PPS has lost sight of its mission. It now much more resembles a Political Payment System.

In fact, many of the policymakers with whom I have spoken during this time have suggested that problems now exist with the Medicare hospital payment system. For example, ProPAC Chairman Altman said as much in comments before the Health Care Financial Management Conference in San Francisco this past June. Mr. Altman stated, "There's absolutely no question that Medicare now disproportionately pays three kinds of hospitals. It overpays teaching hospitals, it overpays disproportionate share hospitals, and it overpays rural hospitals. Now if you happen to be none of the three, you are getting the low end of the totem pole." Later in the Conference, in response to a question I raised about the plight of "High Medicare" hospitals (i.e., hospitals serving a disproportionate amount of Medicare patients), Mr. Altman responded, "But I know you have a problem. You have a very high concentration of Medicare and I don't know what to tell you. I think it's unfair because much of the growth is not in inpatient care anymore, it's in home health and other things, and this latest round I think is terribly unfair. So, I'm not in support of what's going on and if I get an opportunity to go before Congress, I'd tell them. I don't think the thing is right. So, I'm sorry you have such an unfair advantage."

The inequities Mr. Altman outlined are dramatically depicted on the maps prepared by my office, attached hereto. States are shown as lined, dotted or white. One map shows average costs for each state compared to the national case-mix, wage-adjusted average of \$4,494 per case. States shown with dots on this map have high costs compared to the average, white are at the average, and states shown with lines are low-cost states in comparison. The other map shows how the states are faring on a profit/loss basis under the PPS. I would suggest that, if the PPS were working in a fair and equitable manner, high-cost states would be losing money, low-cost making money, etc. However, unfortunately, this is not the case. One high-cost state, New York, shows as dotted -- high-cost yet lined -- profitable under the PPS. Many other average-cost states shown in white come up dotted on the profit/loss map.

This unfair, inequitable distribution of the Medicare budget puts some states in a much better position than others as we enter the era of health care reform. States advantaged currently under Medicare will be better able to bargain with the regional health alliances because they do not carry the Medicare burden that my region must deal with. I believe you cannot have true health care reform without a leveling of the playing field for the largest payor, i.e., Medicare. The data my staff utilized to prepare these maps was based on 1990 information. We contracted with the consulting group Lewin-VHI to do the same analysis with 1991 data. Their results were basically the same as our own.

My staff and I have been studying the Medicare program and its payment policies for many years. Our 75% Medicare caseload makes this a situation we can not responsibly ignore. We have accumulated data on virtually every hospital in the nation. We have modeled a new truly prospective payment system. We have developed rates for each and every hospital in all 50 states. Our proposal's main objective is to reward efficient facilities while penalizing those with high costs. We have been able to accomplish this by establishing a standard rate for each state. Hospitals with costs above this wage- and case-mix adjusted standard are penalized. Hospitals with costs below their state standard are granted additional "incentive" payments as a reward for keeping their costs down.

We worked with Lewin-VHI to model the "incentive" amounts. We think you would be amazed by the amount of money the Medicare system can save by adopting our proposal. The best feature of our savings is that they come only from high-cost facilities. Lower-cost, efficient facilities will finally be recognized and rewarded for their efforts. We do not propose to abandon GME, IME or DSH payments. We believe we have a sensible plan to transition these and segregate them from patient care payments. It is also important that a transition be provided for the "High Medicare" hospitals that Mr. Altman described as having "such an

unfair advantage." Until the playing field is leveled, these facilities need a safety net to safeguard access for large numbers of our senior citizens.

A universal access plan will virtually eliminate the charity care burden for our nation's hospitals. When implemented, it will obviate Medicare's disproportionate share payments. This transition is still, most likely, several years away. In the interim, we would propose a better method to identify those facilities most in need of the DSH payments. The current method, in place for many years, identifies the need for DSH payments based on a facility's Medicaid population. It is assumed that if you have a larger than average amount of Medicaid patients, then you must also have a large charity care population. This is not necessarily the case. In fact the opposite could be true. If a particular state has a good system for identifying and qualifying patients for Medicaid, that state also, as a consequence, may have lower populations of charity care patients. Correspondence I have had with ProPAC indicates their agreement with this theory. ProPAC Executive Director Dr. Donald Young in a letter to me this year stated, "...These mechanisms...do a fairly poor job of matching payments to the level of uncompensated care provided by individual hospitals. However, due to the lack of another mechanism to pay for uncompensated care directly, Congress has thus far chosen to continue the basic IME and DSH design that has been in place for several years."

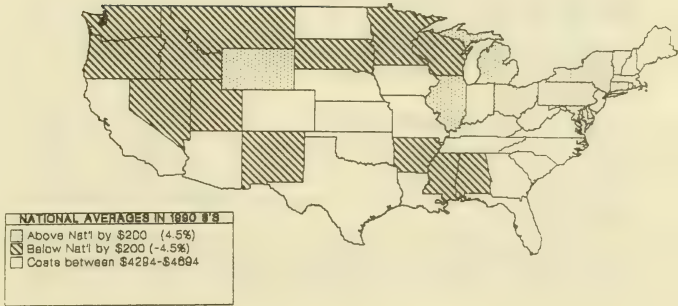
For the past few years there has existed another mechanism to better identify real charity care costs for each hospital. American Institute of Certified Public Accountants (AICPA) guidelines now require each institution to segregate and report their charity care and bad debt numbers in their audited financial statements. I would recommend that Medicare utilize the audited figures for charity care to establish eligibility for DSH payments henceforth, pending transition to a universal access plan.

Currently, under the PPS, bottom line performance from state to state can vary from 25%-30% (i.e., some losing 15% while others have a 15% profit). In our model for more equitable, efficient PPS payments, we have been able to reduce this variation down to about 5% (i.e., all states getting paid about 92%-97% of their costs). We have accomplished this utilizing the exact same dollars currently being spent by the Medicare program. Total expenditures can be "dialed" up or down depending on how much of an "incentive" is paid to the efficient facilities. We believe our proposal results in a fairer distribution of the limited Medicare dollars.

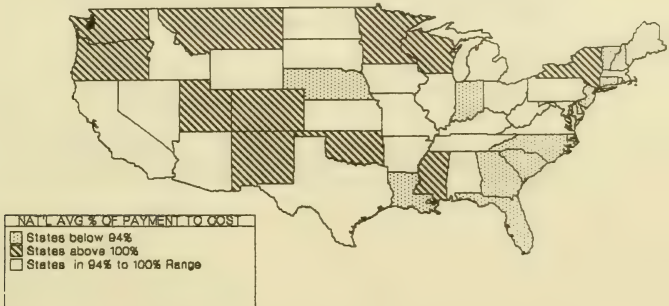
President Clinton has identified reductions in the Medicare program as the primary source of funding for his health care initiatives. His proposal hits all facilities irrespective of their current position. Low-cost, well-utilized, efficient facilities are hit just as hard as high-cost institutions. "High Medicare" hospitals will be especially punished. I suggest our proposal, which identifies high-cost, inefficient operations as the target for the largest reductions, is a fairer approach. Rather than using an ax and causing irreparable harm to needed, well-run facilities, I believe we should first make a surgical strike to identify and remove unnecessary high costs. Our proposal can accomplish this and at the same time send out a warning for all hospitals to get their costs under control.

We have shared an outline of our proposals with ProPAC and HCFA. We would greatly appreciate an opportunity to meet with them and Members of this Subcommittee to further discuss the details of our proposal. I would be happy to respond to any questions you might have at this time or a future date. Again, thank you for the opportunity to appear here today.

UNITED STATES



UNITED STATES



Mr Chairman, I mentioned at the outset of my remarks that I am serving as the chairman of the Association of High Medicare Hospitals. These hospitals, by necessity, have become some of the lowest cost hospitals in the country. They are typical of the kinds of providers I have been talking about. They have responded to the incentives of PPS. Yet, as I pointed out, the system has penalized efficiency.

Your former colleague and former ranking minority member of this subcommittee, Bill Gradison was quoted in the Washington Post in September of 1991,

Medicare has become such a stingy payor that if a hospital were to serve only Medicare patients, it would soon have to close its doors.

WHAT ARE HIGH MEDICARE HOSPITALS?

High Medicare hospitals are those providing inpatient care primarily to aged and disabled Medicare beneficiaries. With a Medicare inpatient utilization of 65 percent or more of total inpatient days, these hospitals are very dependent on Medicare payment policies.

The American Hospital Association (AHA), using thresholds of 65 percent inpatient days or 65 percent Medicare discharges, has determined the number of high Medicare hospitals to be 565 in PPS year five and over 700 in PPS year six (FY 1989). One-third are in urban areas and the other two-thirds serve rural America.

HOW ARE HIGH MEDICARE HOSPITALS FARING UNDER PPS?

ProPAC analysis of PPS 7 data reveals the following:

Urban Hospital Margin Data

PPS margins

- o Urban high Medicare hospitals have lower aggregate PPS margins than do urban medium and low Medicare hospitals. (high: -5.2 percent; medium -1.1; low 6.4 percent)
- o 63.4 percent of urban high Medicare hospitals have negative margins vs 57 percent of urban medium Medicare and 47 percent of urban low Medicare hospitals.

Total margins

- o median total margin for urban high Medicare hospitals is 1.4 percent vs 3.8 percent for urban medium Medicare hospitals and 2.2 percent for urban low Medicare facilities.
- o a larger portion of urban high Medicare hospitals have negative total margins than do medium and low Medicare hospitals. (high 35.9 percent; medium 19.9; low 25.1)

Other Significant Data**PPS margins**

- o urban high medicare hospitals have higher aggregate PPS margin than do the hospitals in the ProPAC comparison group (-3.9 vs -8.2) but these high Medicare hospitals nevertheless have considerably lower aggregate total margins. (2.4 percent vs 5.2 percent)

The above data demonstrate the extent to which all hospitals rely on the ability to cost shift, and the handicap that high Medicare hospitals operate under. The limited number of days paid for by commercial insurance, in high Medicare hospitals, restricts their ability to make up for Medicare underpayment.

Are Costs A Factor?

Earlier data from ICF/Lewin indicate that high Medicare hospitals have lower costs per case, when adjusted for case mix, than do all other hospitals. (\$3,234 for high Medicare hospitals vs \$3,448 for all others {PPS 5})

The Vulnerability Issue

The above data strongly suggest the peculiar vulnerability of high Medicare hospitals under the PPS system. Every change in the Medicare hospital reimbursement system since the implementation of PPS, including outpatient and the capital pass through, has fallen most heavily on those hospitals that have the highest percentages of Medicare days.

Under Healthcare Reform

Mr chairman, If reform doesn't include Medicare, or, if in the interim process of reforming the Healthcare system, there is not a leveling of the playing field, we risk locking in place, once reform is enacted, a payment system base line that is without equity. At that point we will have put in jeopardy the access and quality of care not only for senior citizens but for healthcare consumers across the US.

Mr. KLECZKA. Beth Derby, president-elect of the Federated Ambulatory Surgery Association.

**STATEMENT OF BETH DERBY, R.N., PRESIDENT-ELECT,
FEDERATED AMBULATORY SURGERY ASSOCIATION**

Ms. DERBY. Thank you.

Good afternoon, Mr. Chairman. My name is Beth Derby, and I am here today as president-elect of the Federated Ambulatory Surgery Association, FASA, the Nation's leading organization of ambulatory surgical centers, or ASCs.

Health care reform in general and managed competition in particular should present extraordinary opportunities for ASCs since payers can be expected to seek lower cost, high-quality alternatives to hospital care. However, the administration's reform plan poses substantial threats to the viability of ASCs.

First, the administration's plan, as embodied in the September draft, does not include the surgical services provided by ASCs in the standard benefits package. And, second, the administration's plan provides no protection for ASCs and other freestanding providers against anticompetitive and exclusionary practices by hospitals and hospital-sponsored provider networks.

Unlike 2 decades ago, ASCs are an integral component of our country's health care delivery system. The 1,700 Medicare-certified or State-licensed ASCs across the country perform nearly 3 million surgical procedures annually, approximately one-third of all outpatient surgical procedures.

The growth of these facilities has been due to patient demand as a result of extremely high satisfaction. We are subject to extensive private sector and Medicare utilization review and, as documented in our written testimony, study after study shows that freestanding ASCs are substantially less costly than hospital outpatient departments.

In light of our growing role in the health care delivery system, FASA was shocked to find that ASC services are omitted from the administration's comprehensive benefits package, while hospital outpatient services were included. Although we have been assured informally that this distinction was not intentional, we urge the committee to ensure that ASC services are included in any benefits package legislated by Congress.

Our second concern with regard to the administration's reform plan arises from its failure to recognize the dominant market power of hospitals in many communities to establish provider networks which essentially squeeze ASCs and other freestanding providers out of the marketplace. Let me assure you that ASCs are entirely willing to compete with hospital-sponsored surgical programs on the basis of price, quality and patient satisfaction. But in many markets, dominant hospitals have demanded that managed care plans and employers name them as the exclusive provider of outpatient care as a condition of providing inpatient services.

As a result of the seemingly innocent bundling of hospital inpatient and outpatient services, ASCs don't even get to the bargaining table. The impact of such practices is to take the competition out of managed competition.

FASA believes that any health care reform plan based on the administration's conceptual framework must include specific measures to prevent hospitals from using their market power to force ASCs and other high-quality, cost-efficient freestanding facilities out of business. This could be accomplished by, among other things, ensuring that there are a multitude of plans offered in each area, several of which are not hospital affiliated.

Also, regional and corporate alliances or other regulatory bodies should exercise oversight responsibility to ensure that hospital-sponsored health plans provide fair opportunities to nonhospital facilities to participate in provider networks.

Additional suggestions are included in the written testimony, and such requirements should be spelled out clearly in Federal legislation and should not be left to the individual States or up to the alliances.

Mr. Chairman and members of the committee, I thank you for allowing me the opportunity to appear and would be happy to answer any questions.

Mr. KLECZKA. Thank you, Mrs. Derby. We will find out later in the week if, in fact, it was an omission on the part of the administration, hopefully, by the end of this week.

[The prepared statement follows:]

TESTIMONY OF BETH DERBY FEDERATED AMBULATORY SURGERY ASSOCIATION

Good afternoon. My name is Beth Derby, and I am here today as President-Elect of the Federated Ambulatory Surgery Association ("FASA"), the nation's leading organization of ambulatory surgical centers, or "ASCs". FASA currently has more than 500 member facilities, most of which provide surgical services in a variety of specialty areas and virtually all of which are Medicare-certified.

I thank the Chairman and the Subcommittee for giving me the opportunity to appear before you to address the Administration's Health Care Reform Plan. Health care reform in general, and managed competition in particular, may present extraordinary opportunities for ASCs, since payers can be expected to seek lower-cost alternatives to hospital care. However, the Administration's reform plan also poses substantial threats to the viability of ASCs.

- * The Administration's plan does not include the surgical services provided by ASCs in the "Guaranteed National Benefit Package" (the "Standard Benefits Package");
- * The Administration's plan appears to extend to ASCs restrictions on physician ownership of health care facilities; and
- * The Administration's plan provides no protection for ASCs and other freestanding providers against unfair and anti-competitive practices by hospitals and hospital-sponsored networks.

ABOUT AMBULATORY SURGERY CENTERS

ASCs developed as an alternative to hospital care and traditional medical service delivery. The ASC industry has grown in scope and size since its inception in 1970. The term "freestanding ASC" refers to both the location of these facilities and the services provided. Freestanding ASCs are generally situated outside of hospitals, and may be located in specially designed, single unit buildings or in office complexes. Freestanding ASCs have fully equipped operating rooms that meet hospital standards and provide all related facility services necessary for the performance of outpatient surgery. ASCs are completely separate and distinct entities from physicians' professional practices, both operationally and organizationally; while many ASCs are owned, in whole or in part, by the physicians who use them, others are organized as separate partnerships or corporations whose ownership structure does not include physicians in any way.

ASCs are now an accepted and established component of our health care delivery system. In 1992, approximately 2,870,000 surgical procedures were performed in ASCs -- over 17% of all surgical procedures and approximately one-third of all outpatient surgical procedures. There are currently approximately 1,700 Medicare-certified or state-licensed ASCs located throughout the country, and the number of ASCs is expected to exceed 2,000 by 1995.

The containment of health care costs has never been more important. With health care costs rising at a rate substantially higher than inflation, the Nation must find an alternative to costly hospital care. Surgery centers unequivocally provide that alternative. A 1993 study of freestanding ASCs conducted by SMG Marketing Group, an independent research organization, indicates that, in 1992, the total average charge per case in a freestanding ASC was approximately \$931, while the total average charge per case for hospital-owned ASCs was approximately 25% higher.

The charges generated by hospital outpatient departments are higher still. On average, procedures at freestanding ASCs cost 47% less than those same procedures at hospitals, according to a study conducted by Blue Cross/Blue Shield of North Carolina. This study showed that facility fees for the removal of tonsils, for example, average \$464 in an ASC, compared with \$998 in a hospital. Likewise, repair of an inguinal hernia, which costs an average of \$601 in an ASC, costs over twice this amount in a hospital. Cataract surgery costs an average of \$835 in an ASC, compared with \$2,012 in a hospital.

Freestanding ASCs perform high quality surgical services at lower costs than hospitals because they maintain low overhead costs and because they can focus on one thing: treating ambulatory patients efficiently. This specialization allows efficient use of personnel and facilities.

These cost savings are not achieved by sacrificing quality. ASCs are the most highly regulated providers of ambulatory medical care. All centers approved for Medicare reimbursement must undergo rigorous inspection for compliance with federal standards, and ASCs in 41 states require state licensure as well. In addition, many ASCs choose to become accredited through the Accreditation Association for Ambulatory Health Care or through the Joint Commission for the Accreditation of Health Care Organizations. ASCs are among the only ambulatory care facilities that are subject to Medicare review by peer review organizations. In a 1988 study, the U.S. Department of Health and Human Services' Office of the Inspector General ("HHS OIG") found that ASCs and hospital outpatient departments provide

"equally safe environments." The OIG further found that Medicare patients prefer ASCs to hospitals for outpatient surgical care.

ABOUT THE ADMINISTRATION'S HEALTH CARE REFORM PLAN

- * Any Health Care Reform Legislation Based On the Administration's Plan Should Include ASC Services In the Comprehensive Benefits Package.

Under the Administration's draft Health Care Reform Plan, hospital outpatient surgical services are included in the Comprehensive Benefits Package, while the same ambulatory surgical services provided by freestanding ASCs are not. This distinction between ambulatory surgical services provided by hospitals and those provided by ASCs is utterly inconsistent with efforts to contain health care costs and is inconsistent with the Administration's apparent intent to refrain from distinguishing among providers according to the "site of service." We have been assured informally that this distinction was not intentional and that it will be corrected in the legislative language to be submitted to Congress.

We urge the Subcommittee to ensure that this modification is made. It is clear that ambulatory surgical services should be included in any Comprehensive Benefits Package, regardless of whether such services are provided in hospital outpatient departments or in ASCs. Excluding ASC services from the Comprehensive Benefits Package will simply ensure that surgical procedures are performed in higher cost hospital outpatient settings, and will utterly reverse the progress that has been made by ASCs in reducing costs over the past two decades.

- * Any Extension of the Prohibition On Physician Ownership of Health Care Facilities Should Not Apply to ASCs.

President Clinton's Health Care Reform Plan also includes an extension of the physician self-referral prohibition to non-governmental payers and to additional services. FASA would strongly oppose any extension of the prohibition on physician ownership to apply to ASCs. ASCs are not subjected to these restrictions under current federal law; in fact, the HHS OIG has recently proposed that physician ownership of ASCs be provided a "safe harbor" under the Medicare/Medicaid anti-kickback provisions.

There is absolutely no evidence suggesting that physician ownership leads to excessive utilization of ASCs, as confirmed by a study conducted by the Florida Health Care Cost Containment Board. Physicians who have invested in an ASC generally use the facility as an extension of their offices for their convenience

and that of their patients. The possibility of financial reward has had little to do with the growth in physician-owned ASCs. We request that this Subcommittee ensure, as it has in the past, that any extension of the physician self-referral legislation in the context of health care reform continue to exempt physician ownership of ASCs.

- * Any Health Care Reform Legislation Should Protect ASCs and Other Freestanding Providers From Exclusionary and Anti-Competitive Practices By Hospitals and Hospital-Sponsored Plans.

Our final primary concern with regard to the Administration's Reform Plan arises from the Plan's failure to recognize the dominant market power of hospitals and the potential impact of "managed competition" on freestanding ASCs and other freestanding providers that are not affiliated with hospitals. ASCs are entirely willing to compete with, and, indeed, participate in, hospital-sponsored programs on the basis of price and quality. Yet, in many parts of the country, hospitals have actively sought to prevent ASCs from offering their services to managed care plans, insurers, and employers. In some markets, dominant hospitals have demanded that managed care plans name them as the exclusive provider of outpatient care, as a condition of providing inpatient services. Because a managed care plan cannot be without a source of inpatient services, plans presented with such a demand often have little choice. As a result, ASCs are eliminated from the managed care arrangement, despite their high quality and lower costs. In other markets, hospitals have developed their own HMOs and PPOs that categorically refuse to contract with ASCs, even though ASCs could provide outpatient surgical care for substantially less than the sponsoring hospitals.

FASA and the Nation's 1,700 ASCs fear that such cost-increasing, anti-competitive arrangements can only become more common under the Administration's Reform Plan. For this reason, we believe that any health care reform plan must not only include ambulatory surgical services in the standard benefits package, but must also include specific measures to prevent hospitals from using their market power to force ASCs out of business. Over the long run, we must keep the "competition" in managed competition.

We ask that, in considering the Administration's Health Care Plan, this Subcommittee consider five specific modifications with regard to surgical centers.

- First, we urge Congress to specifically include the services of ASCs in the minimum benefits package.

- Second, in order to ensure that there are adequate opportunities for ASCs to compete, we propose that Congress require that there be several health insurance plans in each area that are not sponsored or otherwise dominated by hospitals or hospital affiliates and at least one plan that allows for an open panel that would permit the participation of all qualified health care facilities.
- Third, we ask that Congress clarify the antitrust laws to prevent hospitals with dominant market power from tying the provision of inpatient services to the provision of outpatient services.
- Fourth, because we recognize that Federal oversight of provider contracting is not practicable, we propose that such oversight responsibility be delegated to Regional and Corporate Alliances. Alliances should require that hospital-sponsored health plans demonstrate that they have given fair opportunities to non-hospital facilities to participate in their provider networks.
- Fifth, we request that Congress require that Alliances scrutinize the provider contracts of certified health plans, to ensure that plans are not inappropriately excluding freestanding facilities and that providers are not engaging in pricing strategies that will, over the long run, impair competition.

We emphasize that these requirements should be spelled out clearly in federal legislation, rather than being left to individual states or to the Alliances.

Mr. Chairman and Members of the Subcommittee, on behalf of FASA, I thank you for the opportunity to appear before you today, and look forward to working with you to meet the challenges ahead.

Mr. KLECZKA. Our last witness on this panel is Dr. Gumnit. Doctor.

STATEMENT OF ROBERT J. GUMNIT, M.D., PRESIDENT, NATIONAL ASSOCIATION OF EPILEPSY CENTERS; PRESIDENT, MINCEP EPILEPSY CARE, MINNEAPOLIS, MINN.; AND CLINICAL PROFESSOR OF NEUROLOGY AND NEUROSURGERY, UNIVERSITY OF MINNESOTA

Dr. GUMNIT. Mr. Chairman, members of the subcommittee, I am Dr. Robert J. Gumnit, president of MINCEP Epilepsy Care in Minneapolis. I speak today as president of the National Association of Epilepsy Centers, which represents over 50 specialized epilepsy centers in the United States.

Epilepsy is a common and chronic disorder of the brain, afflicting approximately 2.5 million Americans. About 20 percent of epilepsy patients do not attain an adequate level of seizure control. Their seizure disorders are characterized as intractable. For many of these patients, the referral to a comprehensive epilepsy center may be appropriate for evaluation and treatment. And, in that regard, we share many of the same concerns about access that the cancer centers have.

Since most patients with epilepsy cannot be cured, the goal of treatment is to eliminate all seizures without producing side effects. The medical management of this chronic disease is significantly different from and more labor intensive than the acute care interventions that dominate the work of most physicians.

Since our current health insurance system, including the Medicare program, is based primarily on addressing the episodic acute care needs of relatively healthy individuals, many of the needs of the chronically ill are not met.

I want to thank Chairman Stark, Chairman Rostenkowski and Representative Cardin for their outstanding efforts to improve the Medicare DRG classification system for the most complex patients with epilepsy. Even with this strong congressional support, getting HCFA to do anything over the past 4 years has been extremely difficult.

This experience forces me to wonder how patients with epilepsy will fare under national health care reform. What evidence is there that managed care or any other scheme will fully address the special needs and different treatment requirements of all individuals with epilepsy, as well as those with other chronic diseases? I fear they will fare even less well when plans manage costs by rationing care. Since their need is less acute, it is easier, psychologically, to postpone or deny care.

I believe there are three criteria that are essential to meeting the needs of patients with epilepsy:

Health plans must allow for direct access to specialized, comprehensive services for patients with intractable epilepsy.

Health plans must provide coverage for outpatient drugs, and there should be no limitation to prescribing the most effective antiepileptic treatment plan for each patient.

Health plans must provide coverage for rehabilitative, psychosocial, preventive and patient education services which are

essential to maintaining the health status of individuals with chronic diseases like epilepsy.

NAEC would like to work with the subcommittee to determine the best means to incorporate these criteria into the health care reform plan. This could be done in legislation by identifying epilepsy as a chronic disorder which is allowed certain waivers of rules or additional benefits under the health plans and by identifying the comprehensive epilepsy centers as essential providers for patients with epilepsy and assure that all health plans can provide access to these centers for individuals with epilepsy in need of specialized services, no matter where in the country they reside as one-third of the country is not within driving distance of a specialized epilepsy center.

As we consider reforms to our country's health care system, it is imperative that the issues relating to the care and treatment of people with chronic disease be addressed.

I will be happy to answer any questions. Thank you very much.

Mr. KLECZKA. Thank you, Dr. Gumnit.

[The prepared statement follows:]

STATEMENT OF THE
NATIONAL ASSOCIATION OF EPILEPSY CENTERS
TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY
ROBERT J. GUMNIT, M.D.

OCTOBER 26, 1993

Mr. Chairman and Members of the Subcommittee, I am Dr. Robert J. Gumnit, President of MINCEP Epilepsy Care, a comprehensive epilepsy center in Minneapolis, Minnesota and Clinical Professor of Neurology and Neurosurgery at the University of Minnesota. I am here today in my capacity as the President of the National Association of Epilepsy Centers (NAEC), an organization representing over 50 specialized epilepsy centers in the U.S.

At the outset, I would like to bring to the Subcommittee's attention a letter written to Chairman Stark from Mrs. Kate Miles detailing the problems that she has faced for the past seven years in trying to care for her son who has a rare and very severe form of epilepsy. Chairman Stark inserted this letter in the Congressional Record on October 14, 1993 and provided the following introduction:

"Most of my colleagues no doubt have received letters or heard the stories of real people like the Miles family. These individual stories remind us that we seek meaningful health reform to control costs so that we can provide more people with better health care."

I want you to know of our strong interest in working with the Subcommittee to see that national health care reform adequately meets the concerns of the Miles family and those of millions of Americans living with chronic disease.

Epilepsy is a common and chronic disorder of the brain, afflicting approximately 2.4 million Americans. Epilepsy is caused by neurologic injury or a structural brain lesion and characterized by the tendency to have recurrent seizures. Nine percent of the population will have a single seizure sometime in their life and require medical attention. Each year about 100,000 people are diagnosed with epilepsy, and more than two thirds of them are younger than 20.

Approximately 20% of epilepsy patients do not attain an adequate level of seizure control despite appropriate care by general neurologists or epileptologists. Their seizure disorders are characterized as "intractable." For these patients a referral to a comprehensive epilepsy center may be appropriate. At such a center a multidisciplinary team of neurologists, neurosurgeons, psychiatrists, psychologists, social workers and nurses will evaluate patients first on an outpatient basis and then, if necessary admit them to the hospital for a 1 to 3 week comprehensive evaluation involving video/EEG monitoring, cognitive testing and other diagnostic procedures. This comprehensive evaluation is required in order to determine the most effective medical or surgical treatment plan for the patient.

For most patients with epilepsy, the goal of treatment in the absence of a cure is to eliminate all seizures without producing side effects that interfere with a patient's ability to function in daily life. The medical management of a chronic disease is significantly different from the acute care interventions that dominate the work of most of my colleagues here today. Since our current health insurance system, including the Medicare program is based primarily on addressing the episodic acute care needs of relatively healthy individuals, I and others who treat patients with epilepsy expend an enormous amount of time and effort explaining to health insurers the benefits of the preventive and comprehensive services provided at specialized epilepsy centers

and the effectiveness of these services in helping patients who experience uncontrolled or intractable epilepsy. What I have found is that insurers, more often than not, will authorize coverage for these services but lengthy negotiations are necessary to achieve a level of reimbursement that accounts for the higher level of technology and the greater intensity of the multidisciplinary services provided to patients at these centers.

While my testimony is focused on the broader aspects of health care reform, I do want to take this opportunity to thank Committee Chairman Rostenkowski, Subcommittee Chairman Stark and Representative Cardin, for their outstanding efforts to improve the Medicare DRG classification system for the most complex patients with epilepsy. Our Association has been working with the Health Care Financing Administration (HCFA) since 1989, to see that the DRG payment system recognize the highly specialized care provided to patients with intractable epilepsy. The comprehensive evaluation for which these patients are admitted requires a longer than average length of stay and more intensive diagnostic procedures than those provided to Medicare patients most frequently admitted under the two medical epilepsy-related DRGs. Since the DRG weights are based on the more common acute care admissions of elderly patients having seizures, hospitals with comprehensive epilepsy centers are at significant financial risk. Although the Medicare patient population admitted to the epilepsy centers for evaluation and treatment is relatively small (most patients are under 40 years of age and on disability), such inadequate payment rates are frequently delaying and sometimes denying these patients services.

This Committee has been very supportive most recently by including in the House-passed version of the Budget Reconciliation bill a provision offered by Congressman Cardin, directing HCFA to complete the necessary analysis and make appropriate changes to the DRGs for patients with intractable epilepsy. Chairman Rostenkowski and Senate Finance Committee Chairman Moynihan agreed to send a letter to Secretary Shalala with the same directive.

While we appreciate this strong Congressional intervention on behalf of patients with epilepsy, there is no question that getting HCFA to do anything over the past four years has been extremely difficult. This experience forces me to wonder how patients with epilepsy and others suffering from severe chronic disease will fare under national health care reform. What evidence is there that "managed care" or other schemes will fully address the special needs and different treatment requirements for all individuals with epilepsy as well as those with other chronic diseases? I believe there are three criteria that are essential to meeting the needs of patients with epilepsy which are similar for others with chronic disease:

1. Health plans must allow for direct access to specialized comprehensive services for patients with epilepsy who are unable to obtain an adequate level of seizure control despite appropriate care by a primary care physician or general neurologist.
2. Health plans must provide coverage for outpatient drugs. Due to the nature of epilepsy treatment, there should be no limitation (such as standard formularies) to prescribing the most effective antiepileptic treatment plan for each patient.
3. Health plans must recognize the benefits of and provide coverage for rehabilitative, psycho-social, preventive and patient education services which are essential to maintaining the health status of individuals with chronic disease like epilepsy.

President Clinton has proposed a health care reform plan which promotes the use of managed care plans. Coming from Minnesota, I have a lot of experience with HMOs and other managed care plans. In an effort to hold down costs, these plans usually insist that

their "inhouse specialist" provide all levels of epilepsy treatment rather than refer their patients to the nearest comprehensive epilepsy center. Many of the managed care plans manage costs by providing less care or less effective care, which for patients with epilepsy can result in significantly higher long term costs due to frequent hospitalizations. Many of the HMOs in my area, have been convinced of the cost effectiveness of the comprehensive services provided by the epilepsy centers, but it has required extensive negotiations that often have resulted in years of delay in care for patients.

Unfortunately, patients continue to be admitted to hospitals in this country with a diagnosis of *status epilepticus*, a severe state of the disorder that can be fatal (This is where a patient will have one seizure following another with no intervening period of consciousness). Drug therapy available today can prevent this from occurring in all but a very small percentage of patients. The difficulty is in choosing the most effective medication for each patient. Fortunately, for the first time in 15 years, three new drugs were approved by the Food and Drug Administration in 1992 for the treatment of epilepsy. I would hate to see any health care reform plan prohibiting the usage of these long awaited and much needed medications. In the field of epilepsy treatment the least expensive or most well known drug is not always the most effective. There are no "me too" drugs in epilepsy. For these reasons allowing states or health plans to use formularies would be extremely detrimental to epilepsy treatment. The process of making changes to formularies is often long and drawn out and in the mean time the patient continues to have seizures.

The goal of comprehensive care is to address the complete needs of the patients. Therefore, in addition to determining the correct medication or surgical treatment for patients, the center and its multi-disciplinary team of psychiatrists, neuropsychologists, nurses and social workers will provide the physical and occupational therapy, counseling and patient education services necessary to allow patients to function to their full potential. These rehabilitative and psycho-social services are critical to the overall quality of life of an individual. Since most patients with epilepsy cannot be cured, living productively is key.

NAEC would like to work with the Subcommittee to determine the best means to incorporate these criteria for caring for patients with epilepsy into the health care reform plan. There are two approaches which could be combined to address the unique needs of this group. One would be to have the legislation actually identify epilepsy as a chronic disorder which is allowed certain waivers of rules or additional services. The second would be to identify the comprehensive epilepsy centers as essential providers for patients with epilepsy and assure that all health plans can provide access to these centers for individuals with epilepsy in need of these services.

As we consider reforms to our country's health care system, it is imperative that the issues related to the care and treatment of people with chronic disease be addressed. Individuals with chronic disease such as epilepsy will be the true test of any new health care system, because their demands on the system are more immediate and so much greater.

Mr. KLECZKA. Let me start with Ms. Romero.

In your testimony, you indicated that your hospital is up and running, doing a fine job for the community, and now there is the possibility of a new \$47 million hospital being constructed within your shadow. That happens all over the country. In fact, there are surgical suites being added where they are probably not needed in a community. Hospitals are getting MRIs even though the neighbor has one, and they could probably share those types of pieces of equipment.

What would be your reaction to putting in whatever health care bill we come up with some type of certificate of need? Because, knowing full well that health care costs are high, we are trying to retard those increases. And for everyone to have the new doodad on the market seems to me to be not the wisest way to go.

Ms. ROMERO. Louisiana doesn't currently have a certificate of need program. In addition to the new hospital that is being—

Mr. KLECZKA. Does have or doesn't?

Ms. ROMERO. It does not. In addition to the new hospital that is being planned, another hospital in this town is also going to enter the OB market in the next 6 months. Their projections are in the neighborhood of 600 deliveries, compared to our 6,000. It is very evident that they can't do that as cost effectively as we can nor with the highly specialized services we have.

I would very much support a certificate of need program if it is run appropriately at the State level. I think it is very important. And also an antitrust provision that allows hospitals to collaborate.

Right now, whenever I meet with other hospitals in town, I have to have my attorney there because, if I want to specialize in a certain area, I can't talk to them about them not doing that.

So there are a lot of concerns on the antitrust issues. Hospitals need to be focused. They need to specialize. They need do whatever it is they choose to do exceptionally well. If they have the volume, they can do it cost effectively as well as in a very high-quality manner.

Mr. KLECZKA. Thank you. I think the antitrust thing is something that will be addressed, and that will be part of the bill, hopefully.

Let me ask the rest of the panel their ideas on the certificate of need proposal.

Dr. BALCH. I would agree with that also, Mr. Chairman.

In our State of Texas where there is not a COM program, there is radiation therapy centers that are sometimes built across the street from each other in relatively small towns. Another derivative part of that is some of these are physician owned. And I think another part of the legislation has to include some provisions that address physician-owned facilities where they are referring patients to their own facilities for which they have a personal financial investment.

Mr. KLECZKA. Thank you.

Dr. Gumnit.

Dr. GUMNIT. Mr. Chairman, in Minnesota we worked under certificate of need legislation, followed by no legislation, and now new legislation reintroducing the concept. The concept is—

Mr. KLECZKA. Wisconsin is doing the same thing. We had the COM. Then a colleague of mine ran for mayor and had it repealed. And now we are going back to it, but we are lumping along in the restoration.

Dr. GUMNIT. Precisely. The problem is, of course, in the details. Unless there are clearly articulated, agreed-upon national standards and unless the certificate of need area is much broader than a single city or a single metropolitan area, it ends up being a matter of local politics.

We cannot escape the fact that we are placing an incredible burden on providers of highly specialized services if we fragment the decision of whether to provide highly specialized services into 50 or 450 individual jurisdictions. We need Federal policy in this area with clearly articulated national standards and broad regional planning.

Mr. KLECZKA. Thank you.

Any other panelists want to respond?

Mr. FORSMAN. From our perspective, I think some sort of controls over the system, but I think the proposal I talked about before would better handle it. For hospitals, we set a rate that is a standard rate. If hospitals choose to go out and add equipment or services, they do it at their own risk. If they can't do it at the rates we are talking about, some kind of a standard efficient rate, they add at great financial peril on their own. I think you need some kind of controls. I prefer the system to challenge people to reduce costs rather than ask the actual program to be at the cost.

Dr. GUMNIT. The problem with just using cost to control is that you discriminate against low volume, very expensive, unusual treatment. These types of treatments are the first things to go when you decide where to put your resources when you operate a general hospital.

Mr. KLECZKA. Thank you very much.

Mr. Molnar.

Mr. MOLNAR. We operate in 18 States, some with certificate of need requirements, others without. I would concur that there is something needed at the Federal level to eliminate the local politics that play into the final decision.

Mr. KLECZKA. OK. One final point.

On your testimony, if I could summarize it for you, it is, just leave us alone. Is that accurate?

Mr. MOLNAR. Yes. We are very concerned that we are going to be encumbered with a bunch of reporting requirements that are totally unnecessary in our case, since we are not charging for our services.

Mr. KLECZKA. You are saying, since you take no government reimbursement, and you charge nothing to your patients, except for, basic certification—you just want to be left alone?

Mr. MOLNAR. Right. And the other point is we would hope that somehow we get into the referral pattern, where patients are referred to us from—through these programs.

Mr. KLECZKA. Are they not now?

Mr. MOLNAR. Yes, they are.

Mr. KLECZKA. One question I had, because of the nature of your service—and I might add excellent service—why wouldn't other

communities or hospitals just shift to you their most problematic cases, the most high, expensive cases, knowing full well that you are going to do it for nothing?

Mr. MOLNAR. We suspect that this will happen.

Mr. KLECZKA. Is it happening now?

Mr. MOLNAR. Not right now. We are getting referrals, yes, for the more difficult case, but we think the number of referrals will increase substantially under this type of a program.

Mr. KLECZKA. Thank you very much.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Just let me say in a general comment to all of you, I continue to be humbled by the complexity of the system in terms of all of the specific structures providing very real needs for relatively small, but very needful, segments in a society.

And one of the things that scares me to death is that, as we keep our eyes up above the horizon line in terms of this new structure, a lot of very particular, specific needs being met now are not going to be met. It is very, very difficult.

Mrs. Romero, to me, one of my first commitments is to do no harm, to try to make sure that we solve whatever problems we have in the system and not create new ones, but you need to know that all of us up here are very frustrated by the way in which the budget scoring deals with preventive care.

We all know that there are ratios of 3 to 1, 5 to 1, 6 to 1, and sometimes can you get it within the 5 year budget window of analysis. Sometimes it requires a lifetime, even as we continue to define wellness, that clearly there is a quality of life aspect to it which will hopefully become more important to us. But we don't get to score any of that. If we spend money on preventive care that means dollars out of our pocket, and we get no credit for the change in lifestyle of wellness or any other change in the recipient.

It is a very expensive portion of any package if we go heavy on prevention. We are going to do it. We are going to pay out of pocket without getting a return on it because we believe in it. But it is very, very difficult.

Mr. Molnar, I wish you luck in terms of saying that you just want to be outside the system. You want exemptions in the Tax Code and the rest.

I will tell you Dr. Gumnit, as well, there are going to be very few asterisks in this bill as to who and how exemptions are to occur. Perhaps in followup we can get a bit more sensitive in areas that are affected. But, Dr. Gumnit, you said that basically you wanted to make sure that epileptic patients get fair and equitable care and then you outlined what you wanted; and it was basically access, cost, choice, and quality. That is the whole thing we are looking at here, and you want it for a particular subset.

We are going to do the best we can to deliver that, but I am telling you now—and perhaps you already know this well—you folks have got to stay on top of us and this process as we move forward. It is impossible for us to be as sensitive as we need to be in all of these different areas, and you need to make sure that your cares are introduced to us and kept in the forefront because it is going to be impossible for us to do otherwise.

Let me end with a question to Ms. Derby. You were told that the slight was not intentional in terms of bias that was built in. I am more interested in finding out if you had a comfort level that, once it was brought to their attention, your concerns will be taken care of?

Ms. DERBY. I think that is why I am here today and why we rely on Congress.

Dr. BALCH. First, one thing you can get in a helpful way, you can do in terms of prevention, is cigarette tax. The smoking and the illnesses that it is medically proven to cause and creates an enormous health care financial burden downstream and it makes sense to tax heavily those who choose to use cigarettes to pay in the health care system for them because a substantial number of them will become substantially ill because of that.

Mr. THOMAS. The current information that the administration's plan will have an increased tobacco tax of 75 cents a 20 cigarette pack. Is that reasonable?

Dr. BALCH. We would encourage you to make that the maximum, both as a source of income and also as a deterrent, especially for those who are young. And we will support the previous level of \$1 a pack as being a level that would both provide income and act as a deterrent, especially for those who are young and impoverished.

The second comment I wanted to just make is that we have provided before Congress, before an exemption for the freestanding cancer centers under the PPS arrangements, we have data to show that there is uniqueness. And we would be glad to work with your committee and the staff to verify that again.

Mr. THOMAS. Doctor, you need to know that the city of Hope has been very forthright in letting me know and keeping me informed. They do a good job.

Ms. ROMERO. Sometimes it is hard for us to look forward and see what the result of preventive care is going to be. But 40 years ago the OB/GYNs in Baton Rouge got together and raised the seed money for what became one of the first cervical cancer detection labs ever opened in this country.

As a result of that, having done over 1 million Pap smears, the cervical cancer mortality rate for women served in that area is 1.2 per 100,000 compared to a goal for the year 2000 of 1.5 as compared to the population not served by Woman's Hospital in Baton Rouge which has a cervical cancer rate of 9.1. That is very, very substantial. And the cost of treating a woman or any person with terminal cancer is 10 to 1. And cervical cancer, if detected early, can be cured.

Mr. THOMAS. You are absolutely correct. And the reality is that. But we don't operate in a real world with our budget scoring. Everyone knows that is what is going to happen. We just can't get credit for it out of pocket, and it continues to be an extremely frustrating part of this difficult project.

Mr. CARDIN [presiding]. That frustration is shared by both sides of the aisle. The committee did question representatives from the administration as to whether ambulatory care was included, and we are assured that it is included. We will wait now, of course, to see the document that is presented by the President and how it is

responded to by Congress. But I wanted the record to reflect previous questioning of administration officials.

I would also like to compliment all the witnesses on this panel and urge you to please keep your views in this area—keep us informed.

Dr. Gumnit, I appreciate your comments on the efforts that we made in regards to, certainly, epilepsy patients and the difficulty we had dealing with HCFA in the DRG system. What we don't know is how the relationship will work between the required services and the comprehensive benefit package as suggested by the administration and the flexibility of local plans, whether they be alliances or plans, in interpreting how those services are to be provided and how the fees are to be set for those services and how much of that will be determined here in Washington and how much will be determined in our own communities.

To me, that is one of the critical parts of the President's package that needs public airing to make sure that we do develop a system that is sensitive to the cost-saving measures that you all have spoken to.

So I, on behalf of the committee, appreciate your testimony and encourage you to communicate, with the committee, additional thoughts as the bill works its way through Congress.

And thank you all very much.

Dr. BALCH. Could I add—Congressman Stark had a previous question about the hassle factor among the claims processing. I did talk to our claims manager at M.D. Anderson where we process 12,000 claims a month among 300 payers. And of those payers, Medicare is probably our worst in terms of hassle factor. At any one time, we have 700 to 800 denials that we have to address by paper. Even though they agree it is justified, the process doesn't allow us to submit it electronically.

So I hope, as you draft legislation and look for models, that the process of paying for claims that Medicare will not be one of those models.

Mr. CARDIN. I will personally make sure that Mr. Stark is made aware of your reply. He and I differ somewhat on our opinions of Medicare's effectiveness on that. Thank you for responding.

I would like to welcome the sixth panel. Mary Jane Burt, representing the American Association of Bioanalysts; Geraldine C. Williamson, representing the American Association of Occupational Health Nurses; Peter A. Towne, Private Practice Section of the American Physical Therapy Association; Jeanette Bair, from the American Occupational Therapy Association; Suzanne Quatannens, National Federation of Societies for Clinical Social Work; and Bryant Welch, American Psychological Association.

Welcome to the committee. Your entire written statements will be made part of the written record. You may proceed as you so desire, either summarizing your statements or making the points that you believe are important.

We will start with Mrs. Burt.

STATEMENT OF MARY JANE BURT, PRESIDENT, BURT MEDICAL LABORATORY, INC., NEW HAVEN, CONN., ON BEHALF OF THE AMERICAN ASSOCIATION OF BIOANALYSTS

Ms. BURT. Thank you, Mr. Chairman. Good afternoon. My name is Mary Jane Burt. I am president of Burt Medical Laboratories in New Haven, Conn., appearing on behalf of the American Association of Bioanalysts.

Our organization represents the owners, directors, and managers of independent, community laboratories across America. Comprehensive health care reform must provide all Americans with a choice of providers, ensure that patients are protected against inferior health care services, and contain effective mechanisms to control cost.

The administration has succeeded in bringing national attention to these issues, and Congress must now begin the difficult task of passing a reform bill.

There are several concerns we would like to bring to your attention. First, our national health care system must provide consumers with a choice of clinical laboratories. Patients and physicians should be able to select a laboratory based on their own evaluation of quality and cost of service. We are concerned that, under certain managed competition systems, health plans will contract with only one or a very limited number of laboratories. Any legislation passed by Congress should ensure that community laboratories that meet the plan's quality standards are included in the selection pool.

Second, minimum quality standards for laboratory tests must be preserved. The administration has suggested that certain quality control standards under CLIA ought to be relaxed or eliminated. We adamantly disagree with this view. Too many patients have suffered or died because of poor testing. Every patient in this country should be assured that his or her laboratory work will be handled in accordance with minimum standards of quality, regardless of whether the tests are performed in an independent laboratory, hospital, or physician office.

Third, health care reform must include effective mechanisms to control costs. Simply ratcheting down the fee schedule for laboratory services has not contained costs. Congress needs to eliminate the financial incentives that encourage physicians' ordering excessive tests. This can be accomplished by including a direct billing requirement and eliminating inappropriate exceptions to the self-referral statutes.

Finally, AAB opposes using the Medicare program as a primary vehicle for financing health care reform. We understand that the administration may request an additional \$10 billion in laboratory savings under the Medicare program. These savings assume the implementation of a competitive bidding scheme and the reinstatement of coinsurance requirements.

We oppose these reductions. The budget reconciliation bill passed by Congress earlier this year already contained a 14 percent real cut in laboratory payments. We are the only sector of the health care community that has been consistently forced to absorb real reductions in reimbursement rates.

Other providers have merely been asked to limit inflation adjustments, and Medicare cuts would have a devastating impact on com-

munity medical laboratories and concentrate services in the hands of a very few large national corporate laboratories.

I appreciate the opportunity to appear before you today and would be pleased to answer any questions you might have. Thank you.

Mr. CARDIN. Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF THE
AMERICAN ASSOCIATION OF BIOANALYSTS
REGARDING

PROPOSALS FOR HEALTH CARE REFORM

October 26, 1993

The American Association of Bioanalysts ("AAB") appreciates the opportunity to present testimony regarding proposals for health care reform. Our Association represents the owners, directors, and managers of independent community laboratories across America.

AAB strongly supports the enactment of legislation providing all Americans access to comprehensive health care services. Health reform legislation must provide a choice of providers, ensure that patients are protected against inferior health care services, and contain effective mechanisms to control costs. The Administration has succeeded in bringing national attention to these issues. Congress must now begin the difficult task of passing a reform bill. As you begin this process, there are several issues that are particularly important to the laboratory industry that we would like to bring to your attention.

A. Health Reform Must Offer a Selection of Laboratory Service Providers, Including Community-based Laboratories When Available.

Some versions of the managed competition model such as the one included in the September 7 White House Draft Memorandum provide approved health plans broad discretion in contracting for ancillary services. We are concerned that the approved health plans will limit participation in these plans to one or two large corporate laboratories and arbitrarily exclude independent community medical laboratories from participating based on their size, scope of services, or geographical service areas.

The health reform legislation approved by Congress should include language that requires approved health plans to offer a selection of approved laboratories and should include independent community based laboratories in that selection whenever possible. Limiting the number of laboratories actually reduces competition. Independent community based laboratories have been particularly important in providing services to rural, nursing home, and underserved populations.

B. Health Care Reform Legislation Should Not Reduce the Quality of Clinical Laboratory Testing

Minimum quality standards for laboratory testing must be preserved. The Administration has suggested that certain quality control standards under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") ought to be relaxed or eliminated. We adamantly disagree with this view. Too many patients have suffered or died because of poor quality testing. Every patient in this country -- urban, suburban, or rural -- should be assured that his or her lab work will be handled in accordance with certain minimum quality standards regardless of whether the tests are performed in a independent laboratory, a hospital, or a physician's office.

In 1988, Congress unanimously passed legislation to protect consumers from inaccurate laboratory testing by establishing minimum quality standards that must be adhered to regardless

of the testing site. This bill was approved following a series of major reports in the print and electronic media exposing substandard cytology testing and unregulated testing in physician offices. The Wall Street Journal won a Pulitzer Prize for articles on inferior laboratory testing, the Inspector General at the Department of Health and Human Services issued reports calling for the regulation of physician office testing, and several local and national news networks focused additional public attention on this subject.

After five years of delay, the Department of Health and Human Services is finally prepared to implement this law. Many of the requirements included in the implementing regulation are not as stringent as under previous regulations governing independent laboratories. Many tests have been exempted from regulation. Nevertheless, the Department has established, for the first time, minimum standards that will apply to all testing sites. Unfortunately, it now appears that Administration intends to further weaken the CLIA requirements and, if possible, may even try to exempt physician office laboratories as part of the health reform package. This would be a very serious mistake.

The need to protect patients against poor testing has not diminished in the last five years. Just last month, the New York Times reported that a woman in Rhode Island died of cervical cancer following four negative Pap smears in eight years. A subsequent investigation revealed that each of these tests was incorrectly read. Review of 1,190 of the hospital laboratory records has already discovered an additional seventeen women with varying stages of cancer who were incorrectly told that they were healthy. The hospital is now reviewing the records of over 19,000 women who were tested between 1988 and May 20th of this year.

The rapid proliferation of in-office testing equipment in the five years has also raised substantial concern. While these systems have proven popular with physicians as a mechanism to increase income, there is strong reason to be concerned about the quality of in-office testing. The February issue of the Journal of the American Medical Association (JAMA) contains an article that concludes that patients are up to two times more likely to experience stroke and up to three times more likely to have a heart attack shortly after they have been tested by a POL that performs a low volume of tests per month than they would be if they had been tested by a POL or commercial laboratory performing a higher volume of tests.

In addition, AAB proficiency testing data clearly demonstrates that the proficiency testing error rates for previously unregulated laboratories are substantially higher than independent and hospital laboratories. For these reasons, Congress should reject legislative efforts to undercut CLIA and closely review any proposed changes in the regulation to ensure that the changes are consistent with CLIA.

C. Health Care Reform Must Focus on Mechanisms to Curb Unnecessary Laboratory Testing

Health care reform must include effective mechanisms to control costs. Total laboratory expenditures in both the public and private sector are based on the amounts paid per test multiplied by the number of tests ordered by physicians. Reducing the price by itself does not control overall laboratory expenditures.

The government and the private sector have largely controlled and, in fact have reduced, payments per laboratory test. For example, under the Medicare program, the reimbursement rate per test has been radically reduced in the last eight years. A survey conducted in 1991 found that payments for the 15 most commonly ordered tests were only 50-70 percent of 1984 rates. Moreover, earlier this year, Congress approved an additional 14 percent cut in laboratory payments to be implemented over the next three years.

However, Medicare laboratory expenditures continue to grow. This is illustrated by Chart A, which was developed by the Office of the Inspector General at the Department of Health and Human Services. Based on the various fee schedule cuts between 1983 and 1988, the OIG estimated that total 1988 laboratory expenditures should be \$698 million, \$125 million less than the 1983 level. In fact they were \$1.9 billion. Total expenditures continue to rise because little, if any, attention has been paid to utilization. Simply ratcheting down the fee schedule has been tried and does not work.

Any health care reform bill approved by Congress must include mechanisms for eliminating inappropriate financial incentives that encourage physicians to order excessive tests. Nevada is the only state in the Union where a physician cannot profit by ordering laboratory tests for Medicaid patients. Beginning in 1982, Nevada prohibited physicians from billing for these tests. These tests are now ordered by physicians but performed and billed by independent laboratories. The results of the Nevada experiment are startling. Ten years after the program was initiated, the amount spent per recipient on laboratory services is still below the 1983 level. The Nevada experience stands in stark contrast to the Federal Medicare and other state Medicaid programs. This success story is illustrated by Chart B. The chart shows that while Nevada has been able to keep payments per recipient constant during the last ten years, other states have experienced between 300 and 600 percent increases in these payments.

The single most important action Congress can take as part of health care reform to control excessive utilization would be to extend direct billing to private payors. It has become a common practice for physicians to request and receive discounts from laboratories for non-Medicare services. They profit by marking up these tests before billing their patients. Consequently physicians have a substantial financial incentive to order unnecessary tests.

This problem could be corrected by incorporating in the health care reform package legislation similar to H.R. 200, introduced by Chairman Pete Stark (D-CA), and S. 337, introduced by Jeff Bingaman (D-NM) and Howard Metzenbaum (D-OH). These bills extend the current Medicare direct billing requirement to private pay patients.

In addition, health care reform legislation should close any loopholes in physician self-referral statutes. These statutes are integral to eliminating inappropriate financial arrangements between laboratories and physicians that might result in excessive testing. Health reform legislation should ensure that any exceptions to these statutes are absolutely necessary and narrowly drawn to avoid the potential for abuse.

D. Health Care Reform Should Not be Financed Through Further Medicare Reductions

AAB opposes using the Medicare program as a primary vehicle for financing health care reform. The Administration has indicated that nearly \$124 billion of the \$350 billion needed to pay for health care reform will come from Medicare. Laboratories would be asked to pay nearly \$10 billion through the implementation of competitive bidding and the reinstatement of co-insurance requirements. We oppose these reductions because they are unfair and ineffective. The proposed reductions are unfair to both providers and consumers and unreasonable in light of the steep reductions the laboratory industry has already been asked to absorb. Earlier this year, Congress agreed to a 14 percent real reduction in reimbursement rates. This cut, phased in over three years, is much deeper than that applied to almost every other provider organization.

We understand that the Administration has assumed nearly \$2 billion in savings associated with implementation of an undefined scheme for competitive bidding. Past proposals by the Executive Branch in this area have been deeply flawed, raise serious quality questions, and would eventually concentrate all laboratory services into the hands of a few providers who will be in a position to drive up costs in the future. In addition, previous experiments with competitive bidding have resulted in substantial quality problems. Moreover, these schemes have never taken into account the special needs of rural, nursing home and other underserved populations.

We also have been told that another \$8 billion in savings are associated with reinstating the 20 percent co-insurance requirement for laboratory services. This requirement was eliminated in 1984. Co-insurance amounts are rarely more than a few dollars. The costs of billing and collection are usually greater than payments.

It is important to note that, unlike other providers, the laboratory community agreed to accept assignment on all claims in exchange for waiving co-insurance payments as part of the 1984 budget agreement. Reinstatement of the co-insurance requirement, which in most cases cannot be profitably collected, would not be fair particularly given the fact that providers have accepted mandatory assignment. Finally, co-insurance is not likely to have a significant impact on the volume of laboratory tests. Physicians are responsible for ordering these tests, and we are not aware of any major study demonstrating that imposition of co-payments for these services will significantly reduce the volume of testing.

Conclusion

We appreciate the opportunity to present our views to the Subcommittee on these important issues. Enacting a comprehensive health care reform bill will be a difficult task. However, AAB is committed to a plan that provides all Americans health care coverage, including a choice of quality community laboratory services. We look forward to working with you and would be pleased to answer any questions you may have.

PERCENT CHANGE

Growth in Laboratory Expenditures Despite Reductions in Payment

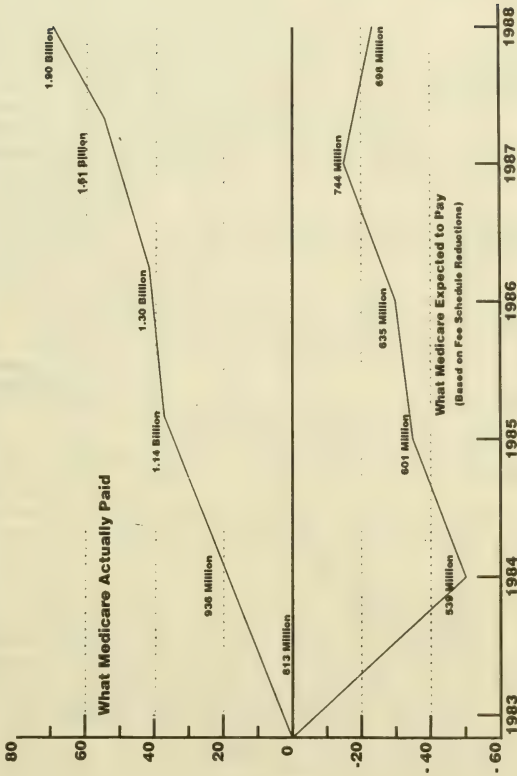


Chart A

Ensuring the appropriate use of Laboratory Services HHS Office of the Inspector General, October 1990

Comparison of State Medicaid Laboratory Expenditures

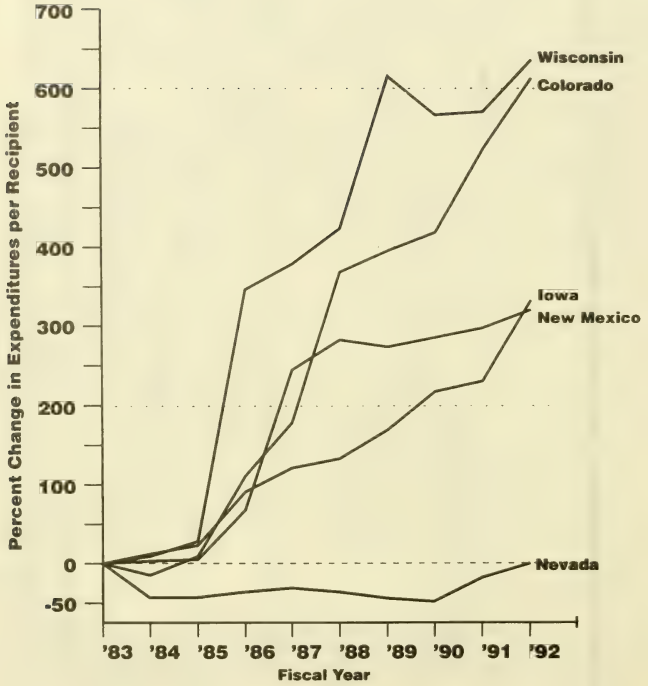


Chart B

Mr. CARDIN. Ms. Williamson.

STATEMENT OF GERALDINE C. WILLIAMSON, DIRECTOR OF COMMUNICATIONS AND GOVERNMENT AFFAIRS, AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES

Ms. WILLIAMSON. I am Geraldine C. Williamson of the American Association for Occupational Health Nurses.

AAOHN is the professional association for more than 12,000 registered nurses who provide health care at the worksite. Occupational health nurses deliver primary care, manage workers' compensation, and conduct health promotion programs that are employer-based, worksite health and safety programs.

Worksite programs for health concerns, ranging from substance abuse, smoking, to back injuries and high blood pressure, have increased dramatically.

A 1992 public health service survey found that 85 percent of private sector employers with more than 50 employees offered at least one health promotion program. Moreover, 44 percent of them have added programs since 1986.

In today's fast-paced society, worksite illness and injury prevention programs facilitate early detection and intervention and encourage safety and health habits. These programs reach high-risk individuals who are not motivated to participate in community-based health initiatives.

AAOHN is concerned that many proposals for restructuring the Nation's health care system will substantially erode worksite health and safety programs by eliminating many of the incentives for operating such programs or even worse by creating disincentives for the programs.

Employers paying a community-rated premium or fixed percent tax of payroll will have no incentive to invest in health and safety promotion since such investments will not reduce their health care costs.

Health reform must maintain, if not expand, the financial incentives to employers who operate worksite health and safety programs. For example, depending on how the health care system is restructured, employers who provide qualified programs could receive a discount in the premium or the tax they pay for health benefits; or they could be allowed a tax credit for the cost of their program.

The association also believes that workers' compensation should remain risk adjusted to encourage the continued operation of the effective programs to minimize the occurrence and the severity of work-related injuries and illnesses.

Any attempt to fold the medical portion of workers' compensation into health reform could discourage employer-based case management services for work-related injuries and illnesses.

Health care rehabilitation and return to work can only be effectively coordinated by a health care professional who has a detailed site-specific understanding of how workers interface with the work environment.

Some health reform proposals limit the tax deductibility or would actually tax health benefits that go beyond the scope of the basic package. Such taxes could create a disincentive for worksite health

and safety promotion unless Congress carefully drafts the legislation to expressly exclude these programs from the definition of a health care benefit.

AAOHN supports the goals of cost-efficient accessible and quality health care for all Americans. We would like to champion a health care reform program that begins with a solid commitment to illness and injury prevention.

To that end, we urge you to adopt reform legislation which includes financial incentives for implementing effective worksite health and safety programs. Such programs are crucial to the creation of a health care system with a high potential for cost savings, because they focus most effectively on preventing injury and illness.

Thank you.

Mr. CARDIN. Thank you.

[The prepared statement follows:]

STATEMENT OF THE
AMERICAN ASSOCIATION OF
OCCUPATIONAL HEALTH NURSES

PRESENTED TO
THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE
OCTOBER 26, 1993

INTRODUCTION

The American Association of Occupational Health Nurses (AAOHN) is the professional association for over 12,000 registered nurses who provide health and safety services at the worksite. Over 22,000 occupational health nurses work in large and small businesses across the country. More than 60 percent of AAOHN members are the only health care provider at their workplace.

Occupational health nurses provide a wide array of comprehensive health and safety services for workers and their families. The primary focus of our work is on preventing illnesses and injuries. Worksite-based nurses are responsible for:

- delivering primary care for occupational and non-occupational illnesses and injuries,
- ensuring compliance with laws and regulations governing occupational health and safety,
- assessing worksite health hazard exposures and operating necessary worker health surveillance programs,
- investigating, monitoring and analyzing illness and injury episodes and trends and developing work procedures and training programs to control workplace hazards,
- conducting health promotion and illness and injury prevention programs,
- managing workers' compensation cases to facilitate return of ill or injured workers to productive work in a cost-effective timely manner,
- designing and implementing worksite accommodations for disabled workers, and
- administering occupational health and safety services and supervising health and safety program planning, policy development, benefit design, and cost control initiatives.

Our Association and its members are extremely concerned because many of the health care reform plans under consideration eliminate or substantially reduce employer incentives for worksite health and safety programs.

ROLE OF OCCUPATIONAL HEALTH NURSING IN PROMOTING WORKSITE HEALTH PROGRAMS

Worksite health and safety programs have become a positive, cost-effective component of our nation's health care system. Under the current health care financing system, responsible

employers who provide health insurance for their employees have been able to decrease their costs by sponsoring successful wellness programs.

A recent comprehensive review assessing the impact of worksite health promotion programs concluded that such programs can reduce annual health care costs per employee by as much as \$865. J. Opatz, D. Chenoweth, and R.L. Kaman, Economic Impact of Worksite Health Promotion, Association for Worksite Health Promotion Publications, 1990, Northbrook, IL. It is, therefore, not surprising that 81% of private worksites with 50 or more employees now offer some form of health promotion activity. U.S. Public Health Service, National Survey of Worksite Health Promotion Activities Final Report, p 30 (1992). Nor is it surprising that self-insured worksites are more likely to offer on-site wellness programs than are worksites that are insured through an insurance company. *Id.*

Worksite health promotion is a particularly effective way to reduce spiraling employee health care costs in today's fast-paced society. See K. R. Pelletier, A Review and Analysis of the Health and Cost-Effectiveness Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs, 5 Am. J. Health Promotion (1991). The worksite provides a convenient setting for employees and it offers the peer support that many people need to sustain healthy habits. With its captive audience of a broad cross-section of people, the worksite also provides a way to reach high-risk workers who are not likely to participate in community-based programs.

The broad scope and effectiveness of these programs has been documented by many individual companies and AAOHN members. The American Telephone and Telegraph Company estimates it avoids \$1.60 in medical costs for every \$1.00 it spends on health promotion activities such as smoking cessation, exercise and nutrition counseling. Big Companies See Health Costs Slowing, Wall St. J., Oct. 22, 1993, at A2.

In response to a June 1993 survey of AAOHN members, one occupational health nurse, who provides health care to hospital employees, described the scope of her practice, saying:

We have a broad scope employee health program and work closely with the in-house employee assistance program, as well as the employee wellness program. (We are all part of human resources and work as a team.) Safety is closely integrated. All statistics are shared and interventions are planned and implemented with all departments involved. Employee health provides pre-placement and annual health screens, immunizations, drug screening, follow up for exposures to communicable disease, blood exposure management, return to work clearance, workers' compensation treatment/case management, respiratory protection and hearing conservation programs and health counseling and referrals for employees.

Another AAOHN member, who works for a light manufacturing company with 800 employees, reported that her company's occupational health service provides on-site primary care, on-site treatment of illnesses and injuries, return to work/modified work programs, worksite hazard analysis services (safety programs, job analyses, environmental monitoring, audiometry, spirometry, etc.), health surveillance, health promotion/wellness programs, health education for employees and their families, counseling, substance abuse prevention, disability management and case management. Furthermore, this nurse noted that, by implementing this comprehensive worksite-based program, her employer reduced its health care costs approximately \$200,000 in one year.

ROLE OF OCCUPATIONAL HEALTH NURSING IN MANAGING WORKERS' COMPENSATION CASES

In addition to attacking spiraling health care costs through health promotion activities, employers have also implemented programs aimed at controlling unnecessary workers' compensation claims. The ability of an on-site occupational health professional to coordinate all aspects of care from time of incident through treatment, rehabilitation and return to work, to recognize early signs of personal or system dysfunction, to understand the complexities of the particular worksite, and to implement site-specific interventions is critical to the success and cost-effectiveness of these efforts.

Several studies document that an integrated approach to disability prevention, including accident prevention, case management and return to work policies, is most effective in reducing medical claims and wage loss claims for work-related illnesses and injuries. For example, a Michigan study of 220 business establishments with more than 100 employees from 7 different industries found that the most important factors in reducing workplace disability are injury prevention programs and disability management techniques rigorously implemented at the worksite. W. E. Upjohn Institute for Employment Research and Michigan State University, Michigan Disability Prevention Study, May 1993.

Experiences of AAOHN members involved in comprehensive workers' compensation cost-management programs are consistent with the study findings. For example, one occupational health nurse in a company of 1800 employees has established a return to work program for field employees who service photographic equipment. Based on work restrictions, she coordinates with the employees' supervisors (many of whom were initially resistant due to the nature of the work) to accommodate the employees' restrictions, easing the transition back to full-time unrestricted employment or permanent accommodation. In 1992, this program saved 360 work days or the equivalent of one full-time employee for 1-1/2 years.

An AAOHN member working in a community hospital in the southeastern United States reported that a three-phase limited duty program, designed to enhance rehabilitation and to reduce cost and lost work days for employees with work-related injuries and illnesses, resulted in a 50% reduction in both lost work days (from 1323 days in 1987 to 687 in 1992) and temporary disability costs (from \$79,638 in 1987 to \$38,523 in 1992). These results were achieved despite inflation, an increase in employee population from 2929 to 3925, and a rise in average weekly wages from \$308 to \$426.

HEALTH REFORM LEGISLATION MAY SUBSTANTIALLY REDUCE EMPLOYER INCENTIVES FOR WORKSITE HEALTH AND SAFETY PROGRAMS

AAOHN is deeply concerned that many proposals for restructuring the nation's health care system will substantially erode worksite health and safety programs by:

- eliminating many of the incentives for operating such programs, or even worse, by
- creating disincentives for the employers who sponsor or the employees who participate in the programs.

Employers paying a community-rated premium or a fixed percentage payroll tax will have little financial incentive to invest in health and safety promotion programs. Even if these programs are successful, they will have no effect on employers' health care costs since, under the Administration's health reform plan, the employer will pay a fixed premium per worker. Moreover, employers may be reluctant to offer health promotion and injury and illness prevention activities if the programs cease to be tax deductible business expenses. Worse yet, health reform plans that tax employers or employees for benefits that exceed those in a standard benefits package could create disincentives for offering and/or participating in health promotion activities that would be considered taxable income.

Managed competition models for reform also impose structural impediments to worksite care. When employees at a worksite are served by many different health plans, no one will have enough presence to justify the expenditures necessary to provide on-site services. AAOHN believes this situation will result in fragmented care, longer periods for return to work, and increased direct and indirect (decreased productivity and quality, increased training for replacement employees, etc.) costs.

FOLDING WORKERS' COMPENSATION MEDICAL BENEFITS INTO THE NEW HEALTH DELIVERY SYSTEM COULD REDUCE INCENTIVES FOR WORKSITE SAFETY PROGRAMS

Folding workers' compensation into health reform could reduce the financial incentives for worksite injury and illness prevention programs, since premiums or costs to employers may cease to be risk-adjusted for the medical portion of coverage (approximately 40-50% of current costs). Moreover, a fold-in will disconnect the medical and indemnity portions of workers' compensation coverage, making it more difficult for employers and their compensation insurers to closely monitor medical treatments and actively participate in case management. Because health care professionals working for approved health plans will not have a detailed understanding of their patients' job duties or places of employment, case management will be less effective and lost work time may well increase. A study conducted by the actuarial firm of Milliman & Robertson, Inc., estimates that the medical-indemnity disconnect will increase per-case indemnity costs by 30%. American Insurance Association, Workers' Compensation and Health Care: An Actuarial and Economic Analysis of "Coordination" and "Merger", at 24 (1993).

Nurse practitioner-directed programs to manage workers' compensation claims have been successfully integrated into company health and safety programs. In 1988, Hewlett Packard Corporation, with 3500 employees at its Cupertino, California site, instituted on-site assessment, treatment and case management for work-related injuries and illnesses. The nurse practitioner-directed program, with on-site physical therapy, resulted in a 12 percent reduction in workers' compensation premiums the first year and a 7 percent the second year with no appreciable change in employee count. American Nurses Association, Innovation at the Work Site (1993). Amdahl Corporation, a 9500-employee mainframe computer firm in Sunnyvale, California, that is self-insured for workers' compensation, reports a similar experience with its nurse practitioner-directed program focusing on assessment, treatment and case management of work-related illnesses and injuries. Its workers' compensation costs are \$0.33 per \$100 of payroll compared with \$1.12 per \$100 for other self-insured companies in the area. In addition, Amdahl averages 1.8 lost work days per 100 employees compared with 4.28 per 100 for other similarly situated companies. Amdahl attributes most of its cost saving to

on-site care delivery, emphasis on modified duty, and a priority focus on rehabilitation in the on-site fitness center. Id.

RECOMMENDATIONS

To maintain worksite health and safety initiatives such as the ones described above and to encourage establishment of similar programs in other companies, health reform should offer financial incentives to employers who operate worksite health and safety programs. Depending on how the health care delivery system is restructured, employers who provide qualified programs could receive a discount in the premium or the tax they pay for employee health benefits or they could be allowed a tax credit for the costs of their programs.

In addition, workers' compensation should remain fully risk-adjusted to encourage the continued operation of effective programs to minimize the occurrence and the severity of work-related injuries and illnesses. Any attempt to fold the medical portion of workers' compensation into health reform should encourage employer-based case management services for work-related injuries and illnesses. Health care, rehabilitation and return to work only can be effectively coordinated by a health care professional who has a detailed, site-specific understanding of how workers interface with their work environment.

Health reform provisions that limit the tax deductibility of health benefits that go beyond the scope of the basic coverage package should be carefully drafted. Unless the legislation expressly excludes worksite health and safety programs from the definition of a health care benefit, the taxes will create a disincentive for worksite initiatives.

AAOHN also recommends that Congress supplement provisions designed to encourage worksite health and safety promotion included in its health care reform legislation with program elements in OSH Act reform having the same objective. For example, OSHA reform could include incentives, such as a tax credit for meeting or exceeding a particular safety index or a reduction in inspection frequency tied to employee training initiatives, to spur implementation and continued operation of comprehensive worksite health and safety programs.

CONCLUSION

In summary, AAOHN firmly believes that health care reform should provide universal access to high-quality, cost-effective health care which emphasizes health promotion and illness and injury prevention. To be most effective, care should be available where people live and work. Employers and health professionals, recognizing the importance of these principles, are already achieving these goals through worksite health and safety programs. The Association urges Congress to adopt health care reform legislation that provides meaningful financial incentives for implementing and operating effective worksite health and safety programs in companies of all sizes. Such programs are crucial to the design of a health care delivery system with a high potential for cost savings because those programs focus most effectively on preventing illness and injury.

Mr. CARDIN. Mr. Towne.

STATEMENT OF PETER A. TOWNE, P.T., PRESIDENT, PRIVATE PRACTICE SECTION, AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. TOWNE. My name is Peter Towne, and I am here today as an independently practicing physical therapist with three clinics in Butler County in the State of Ohio and as the president of the private practice section of the American Physical Therapy Association, which is headquartered here in Washington, D.C.

On behalf of the approximately 10,000 privately practicing physical therapists nationwide, we would like to congratulate the President for his bold proposal and thank the committee for the opportunity to testify this afternoon to the potential effects on private practitioners and the diverse patient populations which we serve.

The majority of private practice physical therapists have small or solo-type businesses. We are caregivers and small businessmen and women, and we have always been uniquely affected by any health care revision in this country. For the past 37 years, the private practice section has represented the professional interests of private practice physical therapists dedicated to furnishing the public with the highest quality state-of-the-art physical therapy services available in an outpatient setting.

Despite our documented success in delivering high quality, low-cost rehabilitation services, we are concerned about the future of private practitioners in the changing health care environment.

The President's proposal relies, in large part, on managed care to deliver care and hold down costs. We fully support the need to control our health care spending, but we are concerned that such a reliance on managed care only may adversely affect private practice of physical therapy and undermine real competition in the health care system.

In addition to our concerns regarding managed care, I would like to discuss three other tenets of the Clinton proposal that are of particular concern to the private practice physical therapists: The health alliances, as they are currently proposed; the viability of fee-for-service health plans; and, finally, a few words on physician self-referral.

With regard to managed care organizations, which comprise the foundation of the Clinton proposal, private practitioners are incredulous. Few, if any, private practitioners will be able to exist in a health care system which relies heavily or solely on large monopolistic managed care networks.

Although the President's plan would enable physicians to join as many health plans as they wish, no such guarantee exists for the private practitioner. In fact, many of us who have, for decades, delivered high quality care at low cost are currently being excluded from contracting with managed care networks.

Today, highly qualified therapists that are willing to play by the rules promulgated by managed care organizations are being arbitrarily rejected from participating. There seems to be a first-come, first-serve orientation that ignores provision of quality health care services.

By creating a system that relies only on managed care, patient care and freedom of choice will suffer; and many private practitioners will be cut out of the process altogether.

As independent physical therapists, we support the concept of cost-effective care. In fact, we now deliver timely, cost-effective physical therapy treatment in 30 States without physician referral. We are deeply concerned that managed care gatekeepers will restrict medically necessary physical therapy treatments in favor of premium caps and global budgets. Treatment decisions must not be micromanaged, and State practice acts must not be overturned for the sake of cost containment.

In the broader context of how reform would be implemented, the role of health alliances is of particular concern. Specifically, we are concerned that regional alliances would be able to limit the number of health plans available to consumers and providers. And we question the administration's commitment to offering fee-for-service health plans.

Even though the Clinton plan provides for fee-for-service plans, we don't believe they will survive in the long run. These plans will not be attractive to patients because of high copay and deductible provisions not required in the managed care plan.

In short, fee for service, as it is currently proposed, is a punitive option that will do little to promote a competitive environment. Until more quantifiable data is available on the cost effectiveness of managed care, fee for service should remain available as an equal and viable option.

In closing, I would like to address the problem of physician self-referral. We congratulate Chairman Stark for his consistent efforts to prohibit this abusive practice and applaud the President for proposing further restrictions as a part of overall reform.

The significance of the current prohibition is dubious in our opinion. The ban only applies to services covered under the Medicare and Medicaid programs.

We favor a comprehensive ban that would apply to all payers. Furthermore, the failure to address self-referral within a physician's own office leaves a dangerous loophole. Many private practitioners fear that physicians who are forced to divest in outside joint ventures will circumvent the ban by simply employing physical therapists and creating a practice within a practice. The problem will likely be exacerbated by the encouragement of managed care networks and other joint ventures.

I would like to conclude my statement, but I do have other statements that I will submit in the written portion of my statement.

Mr. CARDIN. Thank you.

[The prepared statement follows:]

Private Practice SectionSM

American Physical Therapy Association

1101 Seventeenth Street, N.W.
Suite 1000
Washington, DC 20036
(202) 457-1115
Fax: (202) 457-9191

TESTIMONY OF PETER A. TOWNE, PT PRESIDENT OF THE PRIVATE PRACTICE SECTION-AMERICAN PHYSICAL THERAPY ASSOCIATION

BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH CONCERNING PRIVATE PRACTICE PHYSICAL THERAPISTS AND HEALTH CARE REFORM

OCTOBER 26, 1993

Introduction

Good morning (afternoon), Mr. Chairman and distinguished Members of the Committee. My name is Peter Towne and I am here today both as an independently practicing physical therapist with three clinics in the state of Ohio and as President of the Private Practice Section of the APTA headquartered here in Washington D.C. On behalf of the approximately 10,000 privately practicing physical therapists nationwide, we would like to congratulate the President for his bold proposal, and thank the committee for the opportunity to testify this morning (afternoon) to its potential effects on private practitioners and the diverse patient populations we serve.

The majority of private practice physical therapists have small or solo type businesses. As care givers and small businessmen and women, we have always been uniquely effected by any health care revision in this country. For the past 37 years the Private Practice Section has represented the professional interests of private practice physical therapists dedicated to furnishing the public with the highest quality, state-of-the-art physical therapy services available in an outpatient setting.

Despite our documented success in delivering high quality, low cost rehabilitation services, we are concerned about the future of private practitioners in the changing health care environment. The President's proposal relies in large part on managed care to deliver care and hold down costs. We fully support the need to control our health care spending, but we are concerned that such a reliance on managed care may adversely effect the private practice of physical therapy and undermine real competition in the health care system.

In addition to our concerns regarding managed care, I would like to discuss three other tenets of the Clinton proposal that are of particular concern to private practice physical therapists: the health alliances as they are currently proposed, the viability of fee-for-service health plans and finally a few words on physician self-referral.

Managed Care And The Private Practitioner

With regard to managed care organizations, which comprise the foundation of the Clinton proposal, private practitioners are incredulous. Few, if any, private practitioners will be able to exist in a health care system which relies heavily, or solely, on large monopolistic managed care networks. Although the President's plan would enable physicians to join as many health plans as they wish, no such guarantee exists for the private practitioner. In fact, many of us who have for decades delivered high quality care, at a low cost, are currently being excluded from contracting with managed care entities. Today, highly qualified therapists that are willing to play by the rules promulgated by managed care organizations, are being arbitrarily rejected from participating. There seems to be a first come, first serve orientation that ignores provision of quality health care services. By creating a system that relies only on managed care, patient care and freedom of choice will suffer, and many private practitioners will be cut out of the process altogether.

Managed Care/Questions of Quality

As independent physical therapists we support the concept of cost effective care. In fact, we now deliver timely, cost effective physical therapy treatment in thirty states without physician referral. We are deeply concerned that managed care "gatekeepers" will restrict medically necessary physical therapy treatments in favor of premium caps and global budgets. Treatment decisions must not be micromanaged and state practice acts must not be overturned just for the sake of cost containment.

Health Alliance/Viability of Fee-For-Service

In the broader context of how reform would be implemented, the role of the health alliances is of particular concern. Specifically, we are concerned that regional alliances would be able to limit the number of health plans available to consumers and providers, and we question the Administrations' commitment to offering fee-for-service health plans.

Even though the Clinton plan provides for fee-for-service plans, we don't believe they will survive in the long run. These plans will not be attractive to patients because of high co-pay and deductible provisions not required in the managed care plans. In short, fee-for-service as it is currently proposed is a punitive option that will do little to promote a competitive environment. Until more quantifiable data is available on the cost effectiveness of managed care, fee-for-service should remain available as a equal and viable option.

Physician Self-Referral

In closing, I would like to address the problem of physician self-referral. We congratulate Chairman Stark for his consistent efforts to prohibit this abusive practice, and applaud the President for proposing further restrictions as a part of overall reform.

The significance of the current prohibition is dubious in our opinion. The ban only applies to services covered under the Medicare and Medicaid programs. We favor a comprehensive ban which would apply to all payers. Furthermore, the failure to address self-referral within a physicians own office leaves a dangerous loophole. Many private practitioners fear that physicians who are forced to divest in outside joint-ventures will circumvent the ban by simply employing physical therapists and creating a "practice within a practice". This problem will likely be exacerbated by the encouragement of managed care networks and other joint-venture arrangements.

Guaranteed National Benefit Package

The plan identifies a broad package of basic guaranteed benefits; however, there are several areas which must be refined. For example, the area of care for chronic or congenital conditions does not appear to be adequately addressed. While coverage is stressed for conditions arising out of illness or injuries, there are life-long diseases, such as cystic fibrosis, which can have decreased morbidity or mortality with the appropriate interventions. These do not appear to be well covered under the plan.

Similarly, the plan would continue coverage so long as recovery is documented. Important as this is, it fails to recognize the value of maintaining patients who have plateaued at a maximum level of function. If these patients are denied access to continuing care, they revert to a condition where acute and more costly interventions are required.

Preventive services in general are less than adequately delineated. Despite a well-defined package of clinical preventive services, the plan does not focus on preventive approaches to musculo-skeletal conditions determined through such procedures as scoliosis screening or posture evaluations. Nor does the plan identify the cardiac and pulmonary preventive care provided by physical therapists and others through exercise training/conditioning and consumer education. Preventive care should be emphasized much more strongly than is the case.

We appreciate the inclusion of hospice services in the guaranteed national benefit package and the identification of physical therapy services as one of the covered services. We hasten to point out, however, that physical therapy is not interchangeable with occupational therapy as the language of the plan perhaps inadvertently indicates. Both therapies should be covered services as a part of hospice care, as is the case with Medicare.

We also question the use of the term "therapeutics" to describe services covered in the hospital benefit. We urge that more descriptive terms be used to identify the services intended. Physical therapy should certainly be one of those services.

Finally, we believe that an emphasis must be placed on work related preventive services. This is explained more fully immediately below.

Worker's Compensation

The lack of reference to work-related preventive services is a significant oversight. Currently, a major focus of workers' compensation programs is an emphasis on functional outcome and injury prevention. The fiscal incentives of workers' compensation insurers and employers are prevention and early return-to-work, to save indemnity payments and increase employee productivity. However, work-related preventive services, are not among the services mandated. Unless this oversight is corrected, a major element underpinning workers' compensation will be completely undermined.

We note with a great deal of curiosity the emphasis placed by the plan on "centers of excellence in industrial medicine and occupational therapy". We wonder whether the term "occupational therapy" has been inadvertently confused with the much broader concept of "occupational health". The two terms are not interchangeable. If the reference was intended to be as it states, then we must seriously question the absence of any reference to centers of excellence in physical therapy. Although occupational therapy is certainly an element of many workers' compensation programs, physical therapy is a much more integral and widely used component, constituting on the average over 10% of the total workers' compensation health care services. We would certainly hope that this possible oversight will be corrected in the legislative language due for introduction in late October and that due recognition and coverage of physical therapy, for both prevention and rehabilitation, will be included in the workers' compensation sections.

Creating A New Health Work Force

We applaud the increased focus of the plan on the supply of non-physician health professionals and we welcome the outreach to underrepresented population groups. We especially appreciate the inclusion of primary care loans for "students in nursing and targeted allied health professions". We assume that the example "physician therapy" is actually intended to be "physical therapy" and that the example of "occupational health" is meant to be "occupational therapy".

We are concerned, however, with the pervasive singling out of disciplines such as nurse practitioners and physician assistants for priority treatment. While we begrudge none of these groups the support being offered, we believe a more constructive approach would be to target support for disciplines based on their demonstrated shortages in the health care delivery system.

Along these same lines we urge that the support extended to physicians for the purpose of graduate medical education be extended to non-physician health professionals as well. Nor should the loan forgiveness program for medical students be available only to medical students. The incentives that are being proposed for these specific groups should be available to a broader range of practitioners based on the demonstrated need for their services.

Conclusion

The Private Practice Section believes that many of the initial concerns we have raised throughout the past year relating to health care reform have been substantively addressed, and we appreciate the opportunities we have had for input. The proposal amounts to a solid foundation on which we can work to build a new health care system. We look forward to working with the Administration and the Congress to address the concerns we have raised and to develop a system which will serve the needs of all Americans.

Mr. CARDIN. Ms. Bair.

**STATEMENT OF JEANETTE BAIR, EXECUTIVE DIRECTOR,
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.**

Ms. BAIR. My name is Jeanette Bair. I am an occupational therapist, and I serve as executive director of the American Occupational Therapy Association. Our organization represents 46,000 occupational therapy practitioners and students.

I appreciate the opportunity to appear before the subcommittee today to share our views on elements of the administration's reform proposal as we currently understand it.

We believe the President deserves great credit for making health reform the centerpiece of the Nation's legislative agenda. We applaud his efforts to assure universal coverage for a comprehensive range of health benefits and his recognition of the importance of access to occupational therapy services. We support the elimination of discriminatory insurance industry practices such as preexisting condition exclusions, a crucial reform for individuals with disabilities.

The new initiatives in long-term services and supports are also major steps in addressing the needs of some of the most vulnerable members of our society. These are all critically important elements that should, in our view, be part of any final reform approved by the Congress.

The President's plan would guarantee all Americans a comprehensive package of health benefits including occupational therapy. There are several areas, however, where we believe clarification is necessary.

Occupational therapy is often provided to people following an illness such as a stroke to assist them in recovering function or to compensate for permanent loss of function.

In addition, occupational therapy is widely utilized to assist children born with disabling conditions to help them develop increased functional ability to play, care for themselves, and participate fully in family and community life. The President's proposal may not, however, cover these services.

Under the President's plan, outpatient rehabilitation services will be covered only to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury." Continued therapy is covered only if "function is improving."

This raises concerns about the availability of these services for children who have congenital problems such as cerebral palsy or Down's syndrome. Under the present system, many insurers do provide coverage of these services for congenital problems. For many children these services do not restore function but rather promote development and achievement of full function. These children often require intervention to sustain their functional capacity and prevent further deterioration.

Beyond the needs of children, these services may be required later in life by persons with congenital or ongoing problems. Some administration officials have expressed their belief that the proposed long-term care benefit will cover these services if needed. However, we would emphasize that the proposed long-term care

benefit allows States to include rehabilitation and other services at their option. Thus, there may be no assurance that children or adults will have access to necessary services on a continuing basis in some States.

We understand this issue has been under review with the administration. We strongly urge Congress and the administration to ensure that any final reform initiative bridge the gap and adequately address the needs of children with congenital problems.

Members of our profession provide services to many vulnerable populations including adults and children covered by the Medicaid program. We are concerned that under the President's plan, coverage for services such as occupational therapy will be reduced for those who are currently on Medicaid but are not cash assistance beneficiaries. It appears that those who move from Medicaid coverage to employer coverage under the new plan lose access to critical services, especially services mandated for children under the expanded early and periodic screening detection and treatment benefit. We urge Congress and the administration to address this potential problem to ensure that children are not inadvertently deprived of access to necessary services.

We believe the President's proposal does not sufficiently meet the needs of people with mental illness because it incorporates benefit limits that do not mirror the treatment accorded physical illness under the plan. We urge Congress to make every effort to eliminate distinctions between the treatment of physical and mental illness and further, to assure that the unique mental health needs of children are adequately addressed.

The President's plan does raise concerns about that potential for underservice in a cost containment environment, particularly as it relates to specialized nonphysician services like occupational therapy that will rely on a gatekeeper or primary care provider referral.

Under the President's cost containment strategies, we believe health plans will be compelled toward stricter payment and service volume controls. Under some scenarios all consumers will be at risk, but individuals with chronic conditions or disabilities will be particularly vulnerable. Experience in the managed care environment is replete with examples of financial incentives to restrict access, denials of access to services like rehabilitation therapies, and poor quality. Strong quality assurance mechanisms and adequate avenues for consumer appeals must be built into any reform initiative.

Consequently, we strongly endorse the recommendations for safeguarding people with disabilities in a managed care environment articulated by the Consortium for Citizens With Disabilities (CCD) Health Task Force, a copy of which is attached for the subcommittee's review.

In conclusion, I thank you for the opportunity to present our views. We look forward to working with you and the members of the subcommittee in the months to come as you continue your deliberations.

Thank you.

Mr. CARDIN. Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF JEANETTE BAIR
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.**

Mr. Chairman and Members of the Subcommittee:

My name is Jeanette Bair. I am an occupational therapist and I serve as Executive Director of the American Occupational Therapy Association (AOTA). Our organization, established in 1917, represents the professional interests of 46,000 occupational therapists, occupational therapy assistants and students of occupational therapy. As health and rehabilitation professionals, our members provide services to those disabled by illness, injury or psychological or developmental impairment. The goal of occupational therapy is to enable individuals to achieve a maximum level of independent functioning in their everyday lives. Occupational therapy practitioners provide services to millions of people each year in acute care and rehabilitation hospitals, nursing facilities, freestanding clinics, psychiatric facilities, school systems, in the home and other community settings.

I appreciate the opportunity to appear before the Subcommittee today to share our views on elements of the Administration's reform proposal as we currently understand it.

We believe the President deserves great credit for making reform of the nation's health care system a centerpiece of his legislative agenda and for advancing a comprehensive proposal to achieve that goal. We applaud the Administration's efforts to provide universal insurance coverage for a comprehensive range of health benefits, and the President's recognition of the importance of providing access to occupational therapy for the millions of consumers who need these services each year. We support the recommendations for insurance industry

reform, which would eliminate highly discriminatory practices such as pre-existing condition exclusions, a critically important reform for individuals and families who experience chronic conditions and disabilities. The new initiatives in long term services and supports for those with severe disabilities are major steps toward addressing the needs of some of the most vulnerable members of our society. These are critically important elements that should, in our view, be part of any final reform package approved by the Congress.

The President's initiative presents the opportunity to reform our health care system in a comprehensive manner to improve the availability of health care to all Americans. Comprehensive reform can enable us to examine health care with a wide lens, encompassing a view of health which addresses the needs of an individual to lead a full and productive life. It offers the opportunity to solidify gains made possible by new knowledge in areas such as assistive technology, and to refine and redirect trends such as managed care to better meet the health care needs of Americans. Our goals in health care reform must look to larger issues: to more effectively and productively use our human and financial resources, to enhance each individual's contribution to our society, and to maintain the quality and innovativeness of health care in America. In many respects the President's proposal holds great promise to meet these challenges. However, a comprehensive revamping of health financing and delivery brings with it the potential for unintended consequences and adverse effects. Indeed, we have identified some of what we believe are unintended consequences and will bring those to the attention of the Subcommittee today.

THE PRESIDENT'S PROPOSED HEALTH BENEFITS PACKAGE

The President's proposal would guarantee to all Americans a comprehensive package of health benefits containing an array of important and necessary services. It incorporates broad coverage of occupational therapy as part of hospital inpatient and outpatient services, through the hospice, home health and extended care benefits, and through the plan's outpatient rehabilitation and mental health coverage. We applaud the President for this proposed coverage. As a service which enables individuals recovering from illness or injury or limited by disability to overcome their limitations and achieve full health and productive functioning, occupational therapy is an essential element of a comprehensive system of health care. These services must be available as needed and provided in ways which best meet individual patient requirements enabling them to participate fully in life and society.

Certainly a revamped health care system should serve these larger goals. There are several areas, however, where we believe clarification is necessary regarding the structure of the benefit package and the appropriate availability of occupational therapy and other services.

LIMITED SERVICES FOR INDIVIDUALS WITH CONGENITAL PROBLEMS

Occupational therapy is often provided to people following an illness such as a stroke to assist them in recovering function or to compensate for permanent loss of function. Occupational therapy is also widely utilized to assist children born with disabling conditions to help them develop increased functional ability to play, care for themselves and participate fully in family and community life. The President's proposal may not, however, cover these services.

The limitation stated in the basic benefit package for access to outpatient rehabilitation services (occupational therapy, physical therapy and speech-language pathology services) appears to be more restrictive than current practice. Under the President's proposal, these services will only be covered to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury." Continued therapy beyond a 60-day period is covered only if "function is improving."

This raises concerns about the availability of these services for children who have congenital problems which may not conform to the plan's interpretation of "illness or injury". Under the current system, insurers and providers (e.g., HMO's) vary in coverage of these services for congenital problems, but many do cover them in these circumstances. In addition, for many children these services do not restore function, as the proposal requires, but rather promote development and achievement of full function. These children often require therapy to sustain their functional capacity and prevent deterioration.

Beyond the needs of children, these services may be required later in life by persons with congenital or ongoing problems to sustain, improve or restore function or to prevent deterioration. Some Administration officials, including the President in response to a town meeting question, have expressed the belief that the proposed long term care benefit will pick up these services if needed "over a long term." However, we would emphasize that the new long term care program allows states to include rehabilitation, assistive technology, and other services at their option. Thus there may be no assurance that children or adults will have access to necessary services on a continuing basis in some states. We do support, however, the proposal's emphasis on home and community services, which are preferred by most individuals and families.

We understand this issue has been under review within the Administration. We strongly urge Congress and the Administration to ensure that any final reform initiative bridge this gap and adequately address the needs of children with congenital problems.

MEDICAID

Members of our profession provide services to many vulnerable populations including adults and children covered by the Medicaid program. As we understand the President's proposal, individuals now on Medicaid who are employed will have their health care paid for by their employers, while those receiving cash assistance (AFDC or SSI) will continue to have their health care paid for through the federal/state funding stream and will have access to the current array of Medicaid service.

We have concern that under the President's plan, benefits for services such as occupational therapy will be reduced for those who are currently on Medicaid but are not cash assistance beneficiaries. In other words, those who move from Medicaid coverage to employer coverage under the new plan lose access to critical services.

Under the expanded Early and Periodic Screening, Detection and Treatment (EPSDT) benefit, children have access to all Medicaid-reimbursable services regardless of any duration, scope or coverage limits under the state's Medicaid plan. Under the President's proposal, children in families that are not cash assistance recipients will be covered through the employer mandate and be eligible for the basic benefit package. The basic package is more limited in terms of treatment services and ancillary services than the current Medicaid program. Thus these children, and other low income children, would lose benefits to which they are now or would be entitled. Again, we urge Congress and the Administration to address this potential problem to ensure that children are not inadvertently deprived of access to necessary services.

DURABLE MEDICAL EQUIPMENT

Applying the benefits of assistive technology, including the selection and fitting of durable medical equipment and training in its proper use has long been an area of intervention by occupational therapy practitioners. The President's benefit package would cover durable medical equipment, prosthetic and orthotic devices and training for the use of such items. However, the stated limitation in the plan on the availability of "custom devices" raises serious concerns about individuals having access to devices which promote full and appropriate functioning. Any reform plan must include proper fitting and selection of equipment such as wheelchairs, prosthetic limbs, splints and braces. The benefit appropriately includes training for individuals in proper use of equipment which is a service often provided by occupational therapists. However, the plan must be clarified around the issue of availability of devices to meet changing functional needs as well as physical changes and must include replacements for broken or deteriorated equipment. These clarifications will help assure that people get the effective services which enable them to be independent and productive.

MENTAL HEALTH SERVICES

The profession of occupational therapy has its roots in the field of mental health. Today, occupational therapy practitioners work with people of all ages with mental illness to assist them in accomplishing daily activities and enable them to function more independently in the community. We believe the President's proposal does not sufficiently meet the needs of people with mental illness because it incorporates benefit limits that do not mirror the treatment accorded physical illness under the plan. A promise to move by the year 2001 toward benefit limits which do not discriminate between mental and physical illnesses appears not to be guaranteed and may in fact be dependent on the achievement of system-wide cost savings. Also the benefit structure appears to apply more stringent limits on alternatives to inpatient care, which would undermine efforts to serve individuals with mental illness in the least restrictive, community setting. Similarly, the plan does not recognize an evolving trend to serve the special needs of children in an integrated system of care focusing on early screening and assessment services. We urge Congress to look carefully at these deficiencies and make every effort to eliminate distinctions between the treatment of physical and mental illnesses and to assure that the unique mental health needs of children are adequately addressed.

QUALITY MANAGEMENT

We concur with the President's efforts to ensure that consumers have access to quality health care by establishing a system of national standards. This will help to assure that people receive the services they need and that those services will effectively aid them in achieving full health and functioning.

The National Quality Management Program envisioned under the President's proposal would establish a national system of performance measures, quality controls and practice

guidelines applicable to all health plans, institutions and practitioners. The ability of all health professionals, including occupational therapists and other nonphysician providers, to equally participate in the development of these quality standards is critically important. We urge the Congress to assure participation and representation of all health professionals in all aspects of quality assurance and management.

ACCESS TO PROVIDERS

Assuring consumers appropriate access to necessary health care services and making our system more cost-efficient will require broad provider participation in the health plans among which consumers will choose. The President's proposal notes that it "... does not require any plan to reimburse any particular provider or any type or category of provider. However, each plan is expected to provide a sufficient mix of providers and specialties and appropriate locations to provide adequate access to professional services." We believe that an "expectation" is insufficient to assure the desired outcome, and we urge Congress to incorporate provisions that would prohibit purchasing cooperatives and health plans from denying any type, class or category of health care professional who provides covered services from participating as a qualified provider.

PROVIDER NETWORKS

The President's plan also addresses the issue of physician network joint ventures and additional guidance requiring the application of antitrust laws to their formation. Clearly, nonphysician providers including occupational therapists, physical therapists, advanced practice nurses, optometrists and others will undertake similar endeavors. The Department of Justice and the Federal Trade Commission guidelines that clarify safety zones for hospital and physician joint ventures need additional clarity to address their applicability to the formation of networks by nonphysician practitioners.

COST CONTAINMENT AND CONSUMER PROTECTIONS

The President's plan does raise legitimate concerns about the prospect of underservice in a cost containment environment. Our concerns are particularly for specialized nonphysician services like occupational therapy that will rely on gatekeeper or primary care provider referral. Under the President's proposed cost containment strategies, we believe health plans will be compelled toward stricter payment and service volume controls. Under such a scenario all consumers will be at risk, but individuals with chronic conditions or disabilities will be particularly vulnerable. Experience within the current managed care environment is replete with examples of financial incentives to restrict access, denials of access to services like rehabilitation therapies, and poor quality. Strong quality assurance mechanisms and adequate avenues for consumer appeals must be built in to any reform initiative. The unique needs of individuals with disabilities must be taken into account as we construct a reformed health care system. Consequently, we strongly endorse the recommendations for safeguarding people with disabilities in a managed care environment articulated by the Consortium for Citizens with Disabilities (CCD) Health Task Force, a copy of which is attached for the Subcommittee's review.

In conclusion, I thank you again for the opportunity to present our views. We look forward to working with the members of this Subcommittee in the months ahead as you continue your deliberations and engage in the difficult and complex task of reforming our nation's health care system.

Consortium for Citizens with Disabilities

December, 1992

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

PROBLEMS AND SAFEGUARDS FOR PEOPLE WITH DISABILITIES IN MANAGED CARE

The CCD Health Task Force "Principles for Health Care Reform from a Disability Perspective" were developed to assess the ability of various major health care reform measures to meet the needs of people with disabilities. Since many reform proposals utilize some form of managed care, the CCD has applied these principles and identified a number of major problems in managed care systems.

This document identifies these problems and makes recommendations to improve the ability of managed care systems to better meet the needs of people with disabilities. The CCD believes that it is critical for health care policy makers to recognize that there are at least 43 million Americans with disabilities and a large number of others with special health care needs. This includes individuals of all ages with physical and mental impairments, conditions or disorders, that are severe, acute, or chronic and limit or impede their ability to function.

Problems with/Recommendations for Improvement

- I. Managed care systems often include financial incentives to restrict access, limit or deny care, or provide poor quality care. This is especially detrimental to children and adults with disabilities and those with special health care needs.
 - A. Capitated managed care systems must have the flexibility necessary to permit primary care physicians to refer participants with disabilities to specialists without being financially penalized.
 - B. Primary care physicians in managed care plans must be adequately compensated and not placed at inordinate financial risk.
 - C. Methods for ensuring the financial solvency of managed care entities, particularly capitation models, must be considered. These may include financial solvency requirements for HMOs, mandatory reinsurance, state reinsurance for Medicaid managed care programs, stop-loss coverage, and mandatory capitalization requirements.
- II. Managed care systems often do not include the array of comprehensive health related services needed by children and adults with disabilities.
 - A. Managed care programs must offer a comprehensive benefits package that meets the needs of people with disabilities and special health care needs. This includes such basic benefits as prescription drugs, rehabilitation services, durable medical equipment, such as wheelchairs and other assistive technology, and mental health services.
 - B. Managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.
 - C. Specific services should be provided not only to treat acute and chronic conditions but also to promote and maintain health and optimum functioning and prevent deterioration and secondary complications.

- III. Managed care systems often have limited experience in providing comprehensive services to children and adults with disabilities because of a systemic emphasis on primary care. This leads to limited access to needed specialized services, delays in services, and a lack of continuity of care needed by children and adults with disabilities.
 - A. Managed care systems must offer people with disabilities and special health care needs the option of having a specialist as their "gatekeeper" in the system. This specialist would provide both necessary specialized care (at the specialized rate) and primary care (at the lower primary care reimbursement rate).
 - B. Managed care entities must have specific limits on waiting times for first appointments and for specialty referrals. To assure geographic accessibility of services, there must also be established standards on travel times and distances to both primary and specialized services.
 - C. Managed care systems must be structured to ensure continued, appropriate access to health and health-related services for children and adults with disabilities.
- IV. Managed care systems lack adequate quality assurance mechanisms, as well as effective grievance policies and procedures designed to ensure access to appropriate health services.
 - A. Managed care systems must provide participants with clear information on policies, procedures, and grievance mechanisms and must ensure consumer participation in the establishment of such procedures. All reviews must be conducted in a timely manner. An independent ombudsman program should be required.
 - B. Managed care systems should be required to provide health care service in accordance with nationally accepted prevention and treatment protocols, e.g. protocols for prenatal care, well-baby care, and childhood immunization schedules.
 - C. Managed care systems must have in place timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary" or when a consumer challenges the appropriateness of a proposed treatment. These second opinions must be considered in any grievance review.
 - D. Managed care systems must include the option to disenroll for those participants who are not receiving adequate and timely services.
 - E. Managed care programs must have strict quality assurance provisions that require internal and external audits by independent assessors and the results of these audits should be available to consumers to assist them in choosing a managed care program. Outcome reviews should be a component of this process.
 - F. Additional protections which must be included are satisfaction surveys of enrollees and disenrollees, including current and former providers.

For additional information contact: Co-Chairs of the CCD Health Task Force
 Bob Griss, United Cerebral Palsy Associations, (202) 842-1266; Kathy McGinley, The Arc, (202) 785-3388; Janet O'Keeffe, American Psychological Association, (202) 336-5934; Bill Schmidt, Epilepsy Foundation of America (301) 459-3700; Steve White, American Speech, Language, and Hearing Association, (301) 897-5700.

Mr. CARDIN. Ms. Quatannens.

STATEMENT OF SUSAN QUATANNENS, DIRECTOR OF LEGISLATIVE COMMITTEE, NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

Ms. QUATANNENS. I am Susan Quatannens.

Mr. CARDIN. I apologize for the pronunciation.

Ms. QUATANNENS. Nobody gets it right.

I am the national legislative chairperson for the National Federation of Societies for Clinical Social Work. I am pleased to testify today on behalf of the National Federation.

The Federation is an organization which represents the views of clinical social workers in both the public and private sectors throughout the United States. We are here as advocates for those who cannot speak for themselves, Americans of all ages, economic strata, and geographic areas who suffer from emotional and mental disorders and who need affordable quality care.

We welcome the opportunity to share with you the views of our membership on the standard health benefit package proposed by the Clinton administration.

I am going to say a little about myself. I am a clinical social worker licensed by the Commonwealth of Virginia and the District of Columbia, and I am board certified. I have practiced in the field for more than 20 years and am now in private practice in Alexandria.

Prior to private practice, I worked in the public sector for more than 12 years and recently served on Alexandria's Mental Health, Mental Retardation, and Substance Abuse Board. I worked with adolescents and adults both in individual and family therapy.

Since mine is a general practice, I have seen patients across the diagnostic spectrum who come for a variety of reasons but all of whom share a level of severe distress. In the course of my day-to-day practice, I treat patients who are insured by CHAMPUS, Medicare, private insurance, and self-insured. I have dealt with many of the managed care organizations in the Washington area.

On behalf of the National Federation, we applaud President Clinton's health reform initiative for recognizing the importance of mental health services. We support the administration's proposals for inclusion of universal coverage, affordability of benefits, and elimination of exclusions based on preexisting conditions.

We are pleased that the administration proposes to eliminate discriminatory artificial limits on mental health benefits by the year 2000.

However, we believe that now is the time for equal coverage for people needing mental health service. We do have several more specific concerns.

The administration's plan would pose serious artificial limits on mental health services for those in need of more intense outpatient psychotherapy. Among others, this would include the severely depressed, victims of rape and violence and incest, those with characterological problems, the psychotic and children. Children typically need more extended hospital stays and benefit best from longer courses of treatment.

The National Federation supports parity for mental health coverage and urges the subcommittee to remove proposed discriminatory limits including the 30-visit cap on outpatient psychotherapy care and the 50 percent copay for outpatient psychotherapy.

As clinicians, we know the proposed 30-visit cap will seriously deprive those in need of intense longer term care at a critical stage of their recovery. We believe that the proposed 50 percent copay discourages early intervention and will make mental health treatment outside the financial means of most Americans.

Those proposed limits also promise to flood the public mental health system with those who cannot afford the copay and who don't recover sufficiently within the 30-session limit.

If you want to put together a system which delivers quality care and is cost effective, you emphasize your preventive services. Outpatient psychotherapy, I would submit, is a preventive service. We hope the subcommittee would not be swayed by those such as the National Manufacturers Association who have called upon you to strip mental health coverage from the standard benefit package, "until it becomes clear that we can pay for it, closed quote."

Instead, we urge you to consider the needs not only of the business interests that can afford skillful public relations and lobbying campaigns but also the needs of over 50 million Americans who suffer from mental disorders in any given year. The fact that approximately one-third of adults over 18 will suffer from mental illness or substance abuse problems at some time in their lives is evidence that the mental health coverage is an official benefit needed now by many of your constituents.

The National Federation commends the bipartisan 218 member majority of the House which recently cosponsored and signed H. Con. Res. 52, the Kopetski Resolution, calling for health care reform legislation that ensures every person has access to mental health coverage on a basis equal coverage provided for treatment of physical disorders. We believe the administration's inclusion of a standard mental health benefit is the first step in the right direction toward eliminating discrimination against those with mental illness.

We ask this subcommittee to take the next step by including mental and health substance abuse benefits on an equal basis with benefits for physical illness.

I thank you for listening and would be happy to answer any questions.

Mr. CARDIN. Thank you.

[The prepared statement follows:]

TESTIMONY OF SUSAN QUATANNENS
NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

Mr. Chairman, and Members of the Subcommittee:

The National Federation of Societies for Clinical Social Work welcomes the opportunity to share with the Subcommittee the views of clinical social workers throughout the United States, with respect to the standard health benefit package proposed by the Clinton Administration.

Clinical Social Workers As Providers Of Care

The National Federation of Societies for Clinical Social Work ("National Federation") is the only organization in the United States which solely represents the views of clinical social workers throughout the United States. Clinical social work is one of the four core mental health professions. Our members provide the majority (about 60 percent) of mental health services in the United States, and practice in virtually every setting in the nation's health care delivery system including:

- medical and psychiatric hospitals,
- mental health clinics,
- private practice,
- AIDS treatment facilities,
- managed care firms,
- trauma centers,
- research settings,
- schools, and
- the criminal justice system.

We evaluate, diagnose, and treat the full spectrum of mental and emotional disorders, including anxiety and phobic disorders, more severe illnesses such as manic depressive disorders and schizophrenic disorders, family conflicts and dysfunctions, and work-related problems.

Our members are more likely than other mental health professionals to provide services to the populations most at risk in our society -- the young, the poor, minorities and the elderly. We work with individuals and families in the inner city and in rural areas. We are here as advocates for those who cannot speak for themselves -- Americans of all ages and economic strata and geographic areas, who suffer from emotional and mental disorders, and who need affordable, quality care.

The Administration's Health Care Reform Proposal

The National Federation applauds President Clinton's health reform initiative and its recognition of the importance of mental health services. We support the Administration's proposals for inclusion of universal coverage, portability of benefits and elimination of exclusions based on preexisting conditions. We are pleased that the Administration proposes to eliminate discriminatory, artificial limits on the mental health benefit by the year 2001, but we believe that now is the time for equal coverage for people in need of mental health services.

The Administration's plan would impose serious artificial limits on mental health services for those individuals (especially children) who need more intensive psychotherapy, community services or hospital care. We believe mental health coverage should be on a parity with physical health coverage because mental illness and substance abuse are major causes of morbidity and mortality in the United States. The personal and economic devastation caused by mental illness is no less severe than that produced by physical illness. Individuals, families and communities all suffer from the devastation and loss. The impact on every societal institution is immense.

The National Federation urges parity for mental health coverage through removal of proposed discriminatory limits including:

- removal of the proposed 30 visit cap on outpatient psychotherapy care; and
- removal of the proposed 50% co-payment for outpatient psychotherapy care.

As clinicians, we are concerned that the 30 visit cap on outpatient psychotherapy will effectively force some individuals with serious mental illness or substance abuse problems to terminate therapy at a critical stage in their recovery. Recent actuarial data indicates that the discriminatory annual limit of 30 sessions can be eliminated at a cost of only \$10 per person per year.¹ The National Federation strongly endorses removal of this artificial limit, which is unrelated to the patient's need for treatment.

Even more importantly, unless the discriminatory 50% co-payment is removed, we believe such an excessive cost sharing requirement will effectively place mental health treatment outside the financial means of most Americans.

The Need For Mental Health Coverage

We urge the Subcommittee not to be swayed by business groups such as the National Association of Manufacturers, who are calling upon you to "strip" mental health coverage from the standard benefit package "until it becomes clear that we can pay for [it]."² Mental health coverage must be included now as a standard benefit. Along with the Administration, we believe strongly that comprehensive health care benefits (including mental health coverage) are the first principle of reform. We are heartened that the Administration has publicly stated that mental health is a benefit "it's just not...going to back down on." We hope that each Member of this Subcommittee will similarly commit to your constituents that you will not back down either.

The National Federation urges the Subcommittee to consider the needs not only of the National Association of Manufacturers and other business interests that can afford skillful public relations and lobbying campaigns, but also the needs of the nearly 30 million Americans who suffer from one or more mental disorders in any six-month period. We are confident that the Subcommittee will recognize that attempts by some to eliminate mental health benefits in the guise of "cost effectiveness" are nothing more than attempts to save money by appealing to the stigmatization which historically has accompanied mental illness. The fact that approximately one third of the adult population over 18 will suffer from a mental illness or substance abuse disorder at some time in their lives is evidence of the fact that mental health coverage is an essential standard benefit needed by many of your constituents.

We urge the Subcommittee to pay special heed to the statistics on mental illness among children:

- in 1982, 5,000 children and adolescents committed suicide,
- in 1985, youngsters under 18 years committed over 150 murders and over 100,000 violent crimes,³
- millions suffer from alcohol or drug dependence, of the affected population,
- fewer than one out of five children and one out of eight adolescents receives appropriate treatment.

The dollar cost of untreated mental illness and substance abuse is staggering: \$297.4 billion in 1991, \$136.1 billion of which was attributable to mental illness and \$161.3 billion to substance abuse.⁴ The broader societal costs in terms of lost productivity, lost employment, vehicular accidents, crime and incarceration, hospitalization for related causes, and the drain on welfare and social security funds can hardly be estimated.

Despite these grim statistics, many people suffering from mental illness and struggling with substance abuse fail to seek treatment. According to some statistics only 54% of those diagnosed with schizophrenia and 32% of those suffering from depression are actually treated.⁵ The stigma attached to mental illness persists and has been institutionalized by the structure of the health care delivery system and the manner in which services are funded. Mental health treatment is not in the mainstream of the delivery system and is reimbursed at a rate generally much lower than that provided for physical illness.

The National Federation applauds the bipartisan 218 member majority of the House of Representatives that has co-sponsored H.Con. Res 52, a resolution calling for health care reform legislation that ensures every person will have access to coverage for medically and psychologically necessary treatment for mental disorders, on a basis that is equal to coverage provided for treatment of physical disorders. We view the Administration's inclusion of a standard mental health benefit as recognition that current definitions and delivery of services reflect a regressive movement toward viewing mental illness as a personal flaw or fault. In the weeks and months ahead, this Subcommittee and others will have the opportunity to hear from many organizations whose testimony will show that people who do seek mental health treatment are often penalized when they seek employment, transfer health policies or apply for disability insurance. Treatment may be delayed or neglected until their condition has worsened and has affected not only the individual but the family and the community.

For all these reasons, the National Federation urges this Subcommittee to stand fast in the face of attempts to impose discriminatory limits on mental health coverage. The standard benefit plan should include mental health and substance abuse benefits on a parity with coverage for physical illness in order to destigmatize diseases of the mind and allow successful, cost-effective treatment of the whole person.

Cost Effective Mental Health Care

Mental illness and substance abuse are best treated in a cost effective manner by providing a comprehensive and flexible mental health benefit package which provides a full continuum of services including preventive, outpatient, inpatient, day treatment and rehabilitative care. Such a system achieves cost effective care through early intervention and the creative use of appropriate "levels of services" based on the patient's diagnosis and clinical/functional response to treatment.

Recent attacks on mental health costs have occurred at a time when total health care costs are escalating at a frightening level. Some imply that the cost of treating mental illness has been disproportionate to other health costs and that the treatment of emotional illness is less necessary than that of physical illness. This perception is not only short sighted but misinformed. The cost of treating mental illness has indeed increased, just as have other health care costs. However, there has not been an increase in the proportion of the health care dollar apportioned to mental illness; the cost has remained at about 8 cents of the health care dollar, approximately 10 cents when substance abuse is included. The National Federation strongly supports the Administration's foresight in recognizing that inclusion of mental health benefits as part of the standard benefit package will not disproportionately affect the total cost of the entire health care package.

In response to those who contend that the cost of including mental health coverage as a standard benefit is too high, we invite the Subcommittee's attention to the enormous body of literature documenting the experience of current federally funded health care programs and private insurance plans, which have documented that mental health coverage is cost effective in proportion to the benefits it produces.

The National Federation would hope and expect that before giving serious consideration to any attempt to limit or reduce mental health coverage based on vague charges by business groups, the Subcommittee will analyze the substantial experience and data which clearly show the overall economic benefits of comprehensive mental health coverage. A few examples of data the Subcommittee should consider include:

- The percentage of the health care dollar expended for treating mental illness and substance abuse has varied little in the past 20 years no matter what delivery and/or reimbursement system is used' and only 2% of these total health care expenditures are for outpatient care.'
- Numerous studies show that timely and appropriate mental health and substance abuse treatment shortens the duration of treatment, diminishes the damage done to the individual and society and in turn reduces other health care costs.

- Aetna and Blue Cross studies from the mid 1980's reveal both shorter hospital stays for medical/surgical patients who were provided modest psychological support and lower utilization of medical/surgical services by those treated in brief outpatient psychotherapy.
- Experiments by companies such as Campbell Soup and Union Carbide, who have increased outpatient coverage, have found that their overall health care costs decrease from "double digits to single digits" by as much as 28%. Both companies boast better than 90% satisfaction rates among their users.⁹
- An analysis of 58 cost-offset studies, which reviewed 6.7 million Blue Cross/Blue Shield cases, reported an 85% decrease in medical utilization following psychotherapy. By comparing medical utilization among mental health treatment users and non-users, the analysis found that, while initially some health care costs were higher, these costs eventually leveled off and became lower in every subsequent year. The most dramatic decline was seen in hospital charges for the rapidly growing over-55 population.⁹
- In 1989, Chevron implemented a plan that covered 90% of outpatient charges and 80% of inpatient charges. Chevron found that although its employee assistance plan benefit covered twice as many people as the previous year, total plan costs rose less than 7%.¹⁰

Quality Of Care

Quality mental health care will result from a combination of highly trained, licensed mental health and substance abuse providers working within a health care delivery system that protects the consumer's rights and provides appropriate services.

Quality care is patient-centered care, informed by a clinical assessment and diagnosis, and devised to meet the patient's needs in terms of the focus of treatment, the modality of treatment and the duration of treatment. Progress and outcome are functionally measured. The existence of inpatient, day treatment and outpatient facilities allows flexibility in treatment planning. In such a system individual rates of recovery and psycho-social factors can be considered. The patient's right to be treated in the least restrictive and usually the least costly environment is preserved and confidentiality vigorously protected.

It is essential that the system devised allows easy access to care, and freedom of choice among trained and certified providers. Preservation of therapeutic relationship, once established, is paramount since the relationship between patient and therapist is the central vehicle for treatment. The current managed care system too often results in inaccessibility to treatment or disruption of care by virtue of "preexisting condition" clauses, job change or loss and/or change of insurance coverage by an employer. Any or all of these circumstances can prevent or disrupt therapy with devastating results.

Special consideration should be given to the needs of children and adolescents. The problems of these age groups differ significantly from adults and must have separate protocols for diagnosis and treatment. The benefit structure must provide for collateral work with parents and teachers, which is crucial for success with children.

Today's managed care environment is geared too often toward cost reduction, and not quality of care. Outpatient treatment is reduced based on the faulty assumption that mental health services are "discretionary". Needed care is denied by limiting the number of approved providers, establishing financial disincentives for treatment, and requiring pre-certification. Reviews required by managed care intrude into the provider/patient relationship, requiring the divulgence of confidential information to justify treatment, and can have an adverse effect on treatment progress. Benefit decisions should be based on the severity of the patient's illness, his/her rate of recovery, and environmental stresses - not solely on perceived cost savings. Procedures should be responsive to critical emergency situations so that the patient does not remain at risk due to administrative procedures.

In order to assure quality care, cost containment measures should be based on sound therapeutic standards and practices which have evolved in the mental health professions, rather than be based on a minimalist approach which encourages recidivism and disregard for professional judgment. Ethical utilization review is possible only when conducted independent of the insurer's profit motive and only by reviewers who are experienced licensed mental health practitioners with specialized training in assessment and review.

Regulation And Accountability

The nation's health delivery system should be nationally regulated. The current market approach has been a disaster creating unbelievable chaos, cost escalation, denial of care and a discriminatory two level system. The current form of managed care has magnified the problems with its discriminatory practices and has created a burden on the public system where the long term mentally ill are being dumped.

A new delivery system should contain a basic benefit package which includes mental health. Each entity within it (HMO, IPA, indemnity plan) should be required to offer the same minimum basic package to prevent adverse selection by which the seriously ill are shifted to the Indemnity plan and to public mental health clinics

As a profession, clinical social workers support the notion of accountability of both the provider and the insurer. Currently, only the provider is held accountable while health maintenance organizations and managed care activities fall outside state and federal regulation. An impossible ethical dilemma is created for the provider when treatment is indicated, the insurer denies benefits and the patient is without ability to pay. Patient abandonment is an unacceptable solution. Benefits should be clearly stated. Criteria and interpretive guidelines used for determining access to treatment and/or denying it should be publicly disclosed. Those in the position of reviewing and denying care should be held accountable for adverse benefit decisions and procedures through state and federal oversight. An appeals process must be structured that is clear, fair and efficient.

A research component should be built into the new system. Within it cost-benefit analysis should consider not only clinical outcome and cost of treatment, but also the societal costs of leaving patients untreated. The current system has not been informed by such data. Monetary expenditure has been the major focus resulting in an often biased and regressive approach to cost-benefit analysis. At the same time that our knowledge of the mind and the techniques to treat its ills has become more sophisticated, the funding necessary to apply that knowledge for the benefit of patients has been reduced.

Quality assurance need not be left to the delivery system itself. A workable apparatus for independent review can be created. But in the existing managed care system the third party payer is also the reviewer. This creates a built in conflict of interest. An entity which profits more by spending less on patient care cannot be expected to keep the welfare of the patient foremost in mind. The review system should be independent of the payer and provider. Those entrusted with such serious and far reaching decisions must be well qualified professionals with specific training in review.

We commend the Subcommittee for its efforts to improve the nation's health care system. The clinical social work profession would welcome the opportunity to provide further input to this Subcommittee as the process goes forward and specific legislative proposals are under consideration. In the meantime, if you would like further information about the experience of clinical social workers and their patients in the past and current health care delivery systems, including the abuses experienced by our patients in dealing with today's version of managed care, please do not hesitate to call upon us.

- ¹ Ron Bachman, Coopers and Lybrand, data presented to Administration actuaries, September 29, 1993.
- ² Clay Chandler, "Business Group Cool to Health Plan," Washington Post, October 21, 1993 at A11.
- ³ Federal Bureau of Investigation Uniform Crime Report, Washington, D.C. FBI, 1985.
- ⁴ National Foundation for Brain Research, "The Costs of Disorders of the Brain, 1992."
- ⁵ Charles Hauser, M.D., presentation to Governor's Blue Ribbon Panel on Future of Public Health, March 6, 1991, Colorado Springs, Colorado.
- ⁶ Open Minds, April 1990 Comparison of Studies: Dorothy Rice for the Institute of Health & Aging of The University of California, San Francisco, 1985, 1988; Harwood, Napalitano, Kristianson, and Collins, 1984, Research Triangle Institute; Levine, Daniel and Levine, Dianne, "The Cost of Mental Illness, 1971" ADAMHA 1975.
- ⁷ Hay/Higgins Co. Inc., "Psychiatric Benefits in Employer Provided Health Care Plans - 1992 Report" August 4, 1992; Frank, Richard, Ph.D and David Salkever, Ph.D, Johns Hopkins University School of Hygiene and Public Health, Department of Health Policy & Management, Baltimore, Maryland.
- ⁸ N. Connors, Do You Need A Managed Mental Health Program? Business and Health, February, 1992.
- ⁹ H. Schlesinger, A New Look at Evidence About Reduced Cost of Medical Utilization following Mental Health Treatment, American Journal of Psychiatry, 141, 1985.
- ¹⁰ Mental Health Liaison Group Press Release, "Mental Health Group Disputes Manufacturer's Position," October 22, 1993.

Mr. CARDIN. Dr. Welch.

STATEMENT OF BRYANT L. WELCH, PH.D., SENIOR POLICY ADVISOR, NATIONAL HEALTH CARE REFORM, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. WELCH. Mr. Chairman, I am Dr. Bryant L. Welch, the senior policy advisor to the American Psychological Association.

By way of personal background, I am a board certified clinical psychologist and a licensed attorney. I have been involved in the delivery of mental health services for 20 years working in a State hospital with the seriously mentally ill, community mental health care, and, of late, in private practice.

American Psychological Association very much appreciates the opportunity to testify before you today concerning the administration's forthcoming health care proposal.

We, of course, want to begin by commending President and Mrs. Clinton for the enormous leadership they have shown in this initiative, and particularly for the attention they have given to mental health care.

I know that this committee is well aware of the enormous unmet need for mental health care in this country. Over a lifetime, about one out of every three Americans will suffer from a diagnosable mental disorder. And at any one point in time, there are 28 million amongst us who are suffering from such a mental illness. About half of those are children.

Today, however, we would like to focus on our concerns with the specifics of the Clinton proposal as it has been publicly announced. The devil is often in the details; and if we look specifically at the mental health package, we see a potential tragedy borne of very, very good intentions.

The benefit plan, as you no doubt have heard, is ostensibly designed to care for the more seriously mentally disturbed patients, an objective which we applaud and support.

However, between the hand and the lip lies many a slip. And what in fact is currently publicly proposed by the administration is a benefit structure which has the potential to make sure that institutions, such as private psychiatric hospitals and drug companies, get reimbursed, rather than to assure that patients seek appropriate mental health care.

By designing a benefit which emphasizes almost exclusively drugs and institutional care for those in need of mental health care, the proposal establishes a narrowly focused medical monopoly in the health care field, forces patients into the most expensive and the most high-risk treatments, regardless of whether those treatments are appropriate for their condition or not.

Just by way of simple illustration, the severely limited outpatient benefit makes it impossible for patients suffering from serious emotional disturbances to receive intensive outpatient treatment.

In my clinical practice in North Carolina, I frequently dealt with seriously depressed patients who were oftentimes suicidal. I treated them in intensive outpatient treatment 2 to 3 times a week at a total cost, in today's dollars, of \$200 to \$300 a week. I was able to keep them out of the hospital, employed, and progressing through a therapeutic regimen.

Had those same patients gone into the hospital—which they almost certainly would have without the outpatient treatment—the cost would have been about \$7,000 a week.

The competition, if you will, for the drug companies and the hospitals, is what outpatient psychotherapy represents and what, at present, is being virtually denied by the Clinton plan. It represents a financial bonanza for the drug companies and the hospitals, but it will have the undesirable effect of denying certain patients needed care on the one hand, while driving up costs to such an extent that it will be almost impossible to meet the needs of the seriously mentally ill patients who it seeks to serve.

We strongly support a more flexible benefit which permits the patient to obtain treatment tailored to their need. We specifically point out that many progressive American corporations are recognizing this important principle and are providing better mental health care at lower costs by following it.

The same problem of inflexibility and a monopoly threatens to permeate the rest of the health care system as well. And we specifically request the committee to protect the public's freedom to access nonphysician providers, including not only psychologists but social workers, nurses, optometrists, podiatrists, chiropractors, and others, who have a procompetitive impact on health care costs and who also provide very cost-effective treatments.

We hope that you will be careful in crafting the language of the legislation, regardless of the framework you choose, to meet the goal of universal access by providing for a full range of these nonphysician services and eliminating any barriers to practice that are discriminatory or anticompetitive.

There are other ambiguities in the Clinton plan we hope will be clarified. The term "assessment" is used to describe a service. Such a term needs clarification to ensure coverage of a range of services, including neuropsychological and psychological assessment.

We ask that education, training, and research endeavors under the plan be clarified to explicitly include psychology and behavioral health.

Finally, Mr. Chairman, we would like to express one major concern about the overall structure of the so-called managed competition system. In our experience with managed care, the impact on access to mental health care has been simply devastating. When the provider of care stands in a financial conflict of interest with the recipient of care, the availability of care is jeopardized.

In the managed care model, health care plans will receive fixed amounts of money and then be faced with a decision of how much of that money they want to spend on patient care. We submit to you that our health care system is moving from one extreme in which patient and providers sit down to decide how much of a third-party's money they want to consume—something which clearly leads to over utilization—to the other extreme in which the third-party payer or managed care entity decides how much of their prepaid money they want to spend on the patient and provider.

Arguments that consumer preference will solve this quality of care problem strike us as well intended but naive. Thus, we request very careful consideration of design of quality control mecha-

nisms and most emphatically request that you separate the determination of clinical necessity from financial incentives.

We recognize that in some settings that may involve oversight of our clinical care, something which no one particularly likes. However, we do feel we have a strong case to be made that the oversight should not be made by someone who stands to benefit financially if they conclude that care is not necessary.

Mr. Chairman, we thank you for this opportunity to present our testimony.

[The prepared statement follows:]

**TESTIMONY OF BRYANT L. WELCH, J.D., PH.D.
AMERICAN PSYCHOLOGICAL ASSOCIATION**

Chairman Stark and Distinguished Members of the Subcommittee, I am Dr. Bryant Welch, Senior Policy Advisor for National Health Care Reform for the American Psychological Association. I am a board certified clinical psychologist and a licensed attorney. The American Psychological Association, the largest membership association of over 118,000 psychologists engaged in the study, research, and the practice of psychology, greatly appreciates the opportunity to testify before the Members of this Committee as you review President Clinton's health care proposal and in your vital efforts to remedy the current health care crisis facing our nation. We, of course want to begin by commending President and Mrs. Clinton for the enormous leadership that they have shown in this initiative and particularly for the attention that they have given to mental health care. Today, however, we would like to focus on our concerns with the proposal.

The mental health benefit must be redefined to encourage the use of outpatient psychotherapy services.

The mental health package holds the potential for tragedy born of good intentions. The benefit plan is ostensibly designed to care for the more seriously mentally disturbed patients, an objective which we applaud and support. However, the Administration's proposal offers a benefit structure which does more to make sure that institutions such as private psychiatric hospitals and drug companies get reimbursed than to ensure that patients receive appropriate mental health care. By creating a benefit which emphasizes drugs and institutional care for serious mental disorders, the Administration establishes a narrowly focused medical monopoly in the health care field forcing patients into the most expensive, high-risk treatments regardless of whether these treatments are appropriate for their condition.

Psychologists and many other mental health providers are extremely concerned with the inadequacy of the outpatient psychotherapy benefit outlined in President Clinton's plan. The 30 visit outpatient psychotherapy benefit at 50% copayment in relation to the extremely generous inpatient and partial hospitalization benefit will do no more than codify the current inefficiency and inequity in the mental health delivery system, denying humane care to millions of mentally ill persons and promising to waste billions of dollars in the system.

President Clinton's plan over-relies on expensive hospital-based treatment for significant patient populations which we know are better treated in outpatient settings. All evidence indicates that recent increases in mental health care costs have occurred only in inpatient alcohol and drug treatment and in inpatient adolescent care treatment settings. Research now concludes that nearly 50% of these patients could be treated as effectively or more effectively in outpatient settings. As Senator Wellstone has pointed out in a very recent article, "We can treat ten people once a week for a year of outpatient therapy for what it costs to keep one person in the hospital for 30 days."

The President's outpatient mental health benefit is additionally flawed: for many mentally ill persons suffering from a wide range of mental illnesses, including those with persistent mental disorders and children, who often are best served through least-restrictive outpatient psychotherapy, 30 outpatient visits will not offer effective treatment. Research demonstrates that persons with severe mental illness show improvement after 26 sessions, yet President Clinton's plan will lock many persons out of effective treatment at 30 visits.

Allow me to illustrate the serious consequences of denying access to intensive psychotherapy for patients suffering from serious emotional disturbances. In my clinical practice in North Carolina, I frequently dealt with seriously depressed patients who were oftentimes suicidal. I treated them in intensive treatment two or three times a week at a total cost in today's dollars of \$200 to \$300 a week. I was able to keep them out of the hospital, employed, and progressing through a therapeutic regimen. Had those patients gone into the hospital, which they certainly would have been forced to do without the outpatient psychotherapy, the cost would have been \$7,000 a week. Outpatient

psychotherapy represents competition for the drug companies and hospitals; competition which is being repressed by the President's plan. The plan promises a financial bonanza for the drug companies and hospitals while denying patients needed care and driving up costs to such an extent that it will be almost impossible to meet the needs of the seriously mentally ill patients, needs, ironically, which the Administration's plan had meant to serve.

The President's mental health benefit will be greatly improved to meet the needs of the mentally ill by removing barriers to outpatient psychotherapy limit. Removing the 30 visit limit to an outpatient psychotherapy benefit without arbitrary limit will increase total mental health and substance abuse costs by a mere 3.2%. This minimal increase in mental health costs will offer invaluable treatment for seriously mentally ill persons who would otherwise be improperly funneled into inpatient settings.

Like the 30 visit psychotherapy limit, the 50% copayment will bring the warped incentives of the present system into the reformed system. President Clinton envisions a mental health delivery system which encourages the use of a rich inpatient benefit, while equally efficacious and cost-effective outpatient treatment is discouraged through session limits and relatively high copayments. This envisionment will produce the short-sighted and irrational present structure, where the insurance and hospital industries are promoted and adequate patient care is ignored.

In 1984, the Medicare PPS/DRG system was established so as not to apply to psychiatric units or hospitals. As a result, entrepreneurial dollars were directed into psychiatric facilities, and the number of psychiatric facilities doubled between 1984 and 1988. The result has been, in some cases, disaster, because the explosion of facilities led to "provider demand" for patients, allowing some inpatient providers to abuse the system.

Consider the case of National Medical Enterprises (NME), one of the largest psychiatric/rehabilitation hospital chains in the country. Federal and several State authorities are currently investigating NME on charges that several of its facilities paid "bounty hunters" to snare patients and hold them against their wills in order to receive their insurance reimbursement. NME awarded bonus payments to psychiatric hospital managers for high occupancy rates. Hundreds of patients are now suing NME, relating how they were cruelly treated then miraculously released as "treated" when their insurance coverage ran out.

The 50% copayment for outpatient psychotherapy is relatively high when compared to the inpatient mental health cost-share. As in the present system, the President's plan will pose for the families of mentally ill persons the burdensome alternative of keeping the family member at home with no outpatient treatment, because the cost-sharing is too expensive for them to afford, or using hospital-based services, giving themselves respite and eliminating their financial burden. It is this dual dynamic which has driven costs in the present mental health system. Unfortunately, President Clinton's plan seeks to implement this inefficiency into the reformed mental health delivery system.

People in the reformed system should be encouraged to utilize unlimited outpatient psychotherapy at copayment rates that are similar to inpatient cost-share. Removing the arbitrary outpatient psychotherapy limit and reducing the copayment will produce some cost to the total mental health and substance abuse system but has the greater potential to prevent gross overspending in the much more expensive inpatient system.

In conclusion, we would emphasize our strong belief that the President's mental health benefit, with its emphasis on expensive inpatient mental health care, will burden the reformed system with the warped incentives that have limited patient access to care and spiraled systemic mental health costs. The outpatient psychotherapy benefit is so comparatively limited and the inpatient benefit is so rich, that we believe that mental health outlays will skyrocket, which could eventually lead to a tragic scaling back of mental health benefits and access of the mentally ill to adequate treatment. Additionally, the mental health benefits must ensure that the full range of psychologists' services, now

widely consumed by many persons in our nation, including diagnosis and assessment, neuropsychological services, behavioral and rehabilitative services, are included and accessible.

Non-physician provider services must be encouraged in the reformed system.

A second primary concern of the APA and many other non-physician mental health providers with the Clinton plan is the inconsistency of the draft language that patients will have an effective choice of providers. Any reform plan must ensure that qualified non-physician providers are able and encouraged to render their services in all settings where appropriate, and in so doing, the plan will meet its goal of providing access for all qualified persons.

Although the President's proposed plan does much to eliminate the inappropriate and noncompetitive strangle hold that physicians have held on the health care system through archaic and restrictive statutory and regulatory language, many provisions will continue this tradition of inappropriately prohibiting non-physician mental health providers from rendering care to their patients. Areas of particular concern are:

- ♦ The plan indicates that the National Health Board in the new system will adopt national conditions of participation that providers, plans, alliances, and employers must follow. The plan must ensure that the "provider" and "covered services" definitions outlined in the plan apply to the national conditions of participation in a way that allows health care professionals to provide their services in accordance with their training and competence as determined by State law.
- ♦ The plan must define hospital and other inpatient settings so that patients do not lose access to non-physician provider services and eliminate restrictions in current law that pose barriers or prohibit non-physicians from practicing in accordance to State law. Of particular concern to psychologists is the indication that the President's plan will apply the Medicare "hospital" and "psychiatric hospital" definitions to the entire system. Since the Medicare hospital and psychiatric hospital conditions of participation provisions improperly require physician supervision of patient care, psychologists in several states will lose their present ability to independently supervise and render care for their patients in these settings. Therefore, to ensure access of all patients to qualified psychologists services, the plan must drop the Medicare hospital and psychiatric hospital definitions and ensure that psychologists and other non-physician providers are able to care for their patients according to their training and competence. Additionally, the plan should eliminate arbitrary barriers to hospital membership and appropriate clinical privileges.
- ♦ Several provisions in the draft plan, such as the provisions relating to antitrust enforcement and "safe harbors" in the new system, inappropriately apply only to physicians. These must be reexamined, and psychologists and other non-physician providers must be included where appropriate.
- ♦ The plan must eliminate all discriminatory and anti-competitive practices against non-physicians. The proposal must include language which prohibits any entity or plan from discriminating against a class of health professional. Relatedly, the plan must ensure an appropriate and sufficient mix and representation of all health professionals on the national, regional, and State health boards and health plans.

Of particular concern for psychology is the impact of non-physician restrictions in rural areas. Two-thirds or more of all U.S. counties do not contain a single psychiatric physician, while psychologists are more widely dispersed and available to render mental health services.

President Clinton's plan has proposed to expand mental health services access in rural

areas through investment in inpatient and non-residential infrastructure. This expensive strategy is flawed; creating a medical infrastructure for mental health treatment has failed under the present system to contain costs or offer more efficacious treatment than outpatient psychotherapy. The plan proposes to throw money into the construction of facilities, rather than to provide for the direct treatment of patients through outpatient services rendered by psychologists and other non-physician mental health professionals currently available in rural areas to render effective outpatient treatment.

The plan should instead encourage psychologists and other mental health providers to offer their services in rural areas. The plan offers educational and financial incentives, such as a non-refundable personal tax credit and a deduction of up to \$5,000 in annual student loan interest, for primary care and certain other professionals to render services in rural areas. Given psychology's excellent track record in delivering mental and behavioral health care in rural areas, these provisions should be expanded to include psychologists.

Finally, the proposal lacks any recognition of psychology in the areas of health professions training and research. While the plan specifically provides for increased training opportunities and resources for non-physician providers, psychologists are not listed among those health professional targeted. Licensed psychologists play a major role in providing mental health and behavioral health care across the country, and in rural areas, are among the few professionals available to provide and direct services. It seems illogical not to provide the training support necessary for psychology to continue and thrive in the health delivery system, particularly given the enormous challenge of meeting the goal of universal access in the face of severe physician shortages.

The APA specifically requests Congress to protect the participation of non-physician providers, including not only psychologists but social workers, nurses, optometrists, podiatrists, chiropractors and other groups who have a pro-competitive impact on health care costs and provide very cost-effective alternative treatments. We hope that Congress will be very careful in its review of the language of the Administration's document to make sure that phrases which are now vaguely articulated in the draft document are clarified to provide for the full range of non-physician services. In particular, we point to the word "assessment" to make sure that it includes neuropsychological and psychological assessment. We also ask that education, training and research endeavors under the reform plan be clarified to include professional psychology and behavioral health.

Consumer protections must be implemented to prevent managed care abuses.

A third primary concern of the APA with President Clinton's reform plan is the heavy reliance by "managed competition" on unbridled managed care, which combined with the 30 outpatient psychotherapy limit, will likely be antithetical to effective patient care. Managed care companies, and more recently, other third-party payers, have redefined traditional outpatient care to make it so brief that it is now inappropriate for those mentally ill persons in greatest need.

The managed care financial incentive structure is designed to contain costs by rationing mental health care, instead of addressing the specific needs of the patient. When the provider of care stands in a financial conflict of interest with the recipient of care, the availability of care is jeopardized. Providers are rewarded for limiting care, and patients who are promised a 30 patient limit will likely receive a fraction of their benefit. It is the financial conflict of interest of the provider which jeopardizes patient care.

Scrutiny of managed care should be heightened due to a Government Accounting Office (GAO) study, released just last week, which has concluded that there exists no conclusive evidence that managed care health plans save money. The study concluded that managed care plans saved money by enrolling younger and healthier persons not

by efficiently managing patient care, and that in one study, HMO premiums averaged only 2-4% less than other plan premiums in 1992. This finding directly challenges the President's plan premises that moving beneficiaries into managed care structures will contain costs.

Since managed care will be a foundation of the reformed health care system under the Clinton plan, strong quality standards to protect the patient and to reduce rationing of care must be implemented into the statutory language. The draft outline of the President's plan contains scattered references regarding protection of the privacy of patient data and the implementation of a National Quality Management Program to develop a "quality information and accountability program" to be applied to health plans, but the plan does not contain specific patient protections against potential managed care abuses. At a minimum plans should be required to:

- ♦ separate clinical review from financial interests;
- ♦ adhere to quality standards which protect the patient;
- ♦ use reviewers who are licensed or certified in the areas of mental health care under review;
- ♦ make public the review standards and criteria used in evaluating health care plans;
- ♦ establish arbitration to resolve appeals;
- ♦ ensure that patient confidentiality is protected;
- ♦ implement a review and appeal system which reviews decisions quickly; and,
- ♦ maximize patient choice of services and mental health providers.

Conclusion.

In our testimony, we have emphasized those areas directly related to the delivery of psychological and mental health services. However, we have significant questions about a number of more general features of the plan, particularly the formation and operation of accountable health plans, the development and authority of the National and Regional Health Boards, and the development of systems to evaluate quality of care and provider performance. While time does not permit a thorough discussion of these issues, we will seek further opportunities to discuss these issues with you, Chairman Stark and Members of the Subcommittee when the President's legislation is released.

In summary, the APA commends the President and Mrs. Clinton for their enormous contribution in advancing health care reform, and in particular, their unwavering leadership in developing mental health policy that addresses the long-neglected plight of those with mental disorders. APA stands committed to the goals that the President has set and looks forward to working with Congress to shape and improve the Administration's plan.

Mr. CARDIN [presiding]. Thank you all for your testimony.

One of the comments that has been made about the Clinton plan is that it would move managed care programs to include more nonphysician services than they currently do because they are more cost effective; and as you get a more competitive model, there would be more opportunities for nonphysicians to provide the services that, in some cases, are being provided by physicians.

Most of you have commented on that directly by saying that you still saw obstacles in nonphysician care within the Clinton proposal. But I would be curious whether you see the plan collectively as encouraging more nonphysician use by HMOs or other types of managed care programs.

Mr. WELCH. Mr. Chairman, I think if you look at the language—and please understand, we are all responding to the famous “leak document” and so on which we know is not intended as final language by the administration, so there are many areas of ambiguity in there that we would like to see clarified.

In particular, to see that the managed care companies—we understand that the managed care companies are not going to be required to admit, “any willing provider to their panelists.”

But we would like to see language in there that specifically requires that they adopt a nondiscriminatory posture toward all providers so that there would be selections from different classes of providers so that you would build in, for example, a requirement that they can’t discriminate and exclude psychologists, social workers, or what have you.

Mr. CARDIN. But why would they want to do that if they are trying to provide services in a more cost-effective environment?

Wouldn’t there be an actual tendency to try to include your services in their panel in order to be less costly than a physician providing similar services?

Mr. WELCH. It can go in two directions, sir. First of all, you can have a situation where you have heavy medical influence in the establishment of the particular health plan. That is one danger you encounter. Because there is always—our experience has been there is always jockeying with medical interests by nonphysician groups in order to have a right to offer their services.

There is a lengthy history of that, and the medical interest groups are going to be big and powerful players in any health care system that you design. So we ask for protection from that.

The point that you are raising opens up the other area of concern, which is that they also will cut the quality very low, and what you will find is that it will be exclusively the marginally trained providers who will be included in the plan.

So what we are asking is that you—that you require that there be a range of practitioners whose services have to be made available so that the public has a right to choose in there.

Mr. CARDIN. Require that nationally or locally? Nationally or locally require that?

Mr. WELCH. I much prefer it to be nationally required. Otherwise, you are going to have this issue that will have to be fought out in every jurisdiction and in every health care plan.

And, you know, given for those of us who have been in these guild wars for a long time, we would sure appreciate it if you

would, with the stroke of a pen, say, no more of it; it is going to be the public's right to choose rather than opening it up to areas where, you know, medical interests predominate over the organizational skill of social workers or psychologists or whoever.

So we think there is a great efficiency in you doing it legislatively at the Federal level.

Mr. CARDIN. Mr. Towne, you referred to the subtle—or not so subtle—provisions of the Clinton proposal in encouraging people, in some places penalizing people, to leave fee-for-service type plans and to move toward managed care programs. And if I interpreted your statements correctly, that alarms you.

I would just make the observation that today people are being moved from fee-for-service options into managed care programs in some cases with no choice because of their employer limiting the selection of plans that they can join. I am curious as to why—your experience with managed care programs, as far as the ability to deal with those types of health care plans—the chairman of the committee, Mr. Stark, has asked most panels that appear before us if you had a choice between one type of plan to be in, from the point of view of administrative simplification, would you prefer to be in a fee-for-service plan or Medicare or an HMO?

And perhaps you could just expand a little bit more for me as to why you feel threatened if there is not a fee-for-service option available?

Mr. TOWNE. Mr. Chairman, thank you for the opportunity. The experience that we have had thus far is that many of the HMOs and PPOs out there are choosing to exclude dealing with the small mom and pops, of which we represent a great deal of, because of the perceived activity that we are going to go to large alliances or large managed care entities.

The fact that we are a referral-type of service and still in 20 of the 40 or 50 States, makes us subservient to the medical activity that is out there. You have heard this morning of physician self-referral and abuses that take place, and this is still an entity that is there.

All of these factors still weigh within how we are dealt with as a provider of service, even though it is a valuable service. The managed care entities are finding that they don't have to deal with us because they are looking at bigger and better things in some other entity, and they just think they will employ us as physical therapists.

And we certainly perceive that as a threat. We know it is a threat. I am a practicing PT for 35 years. There are doors that I can't get into because I am a small business. However, one of the tactics that we are trying to enlist out there is to group together in States as networks of groupings of practices, hoping that that will be an avenue that will have to be dealt with because of the bigger entity of representing PT in the outpatient setting as a whole.

Mr. CARDIN. Yes.

Ms. QUATANNENS. Let me comment. We could probably devote the time before talking about managed care, and I wouldn't start that here. But if I just looked at my own practice and what it has

done, the panels in the area where I am have been concocted in such a way they didn't offer them openly.

What they did was solicit some people, and you had to go and find them if you were interested. Those of us that were better established practitioners and also those of us that do a more in-depth kind of psychodynamic therapy sat back a bit and didn't join them right away. And then we found that the panels were closed, and also that kind of closed off a number of patients that we might see.

I would hate to see that, you know, happen again in another system.

The other thing I am convinced they do, because I look at their forms, they will say at the bottom of the form, how many sessions do you typically see a patient, you know, over how many months or how many sessions. And what they are probably doing is running their computers, and they can tell who the therapists are that do longer term, indepth therapy. And those are the people that will be getting no referrals from them. That has nothing to do with patient need or understanding of the patient.

Mr. CARDIN. Of course, the Clinton proposal attempts to deal with that through the outcome quality analysis information that would be available to consumers in selecting which plans and which providers to use to try to get at the quality differences.

And let me also point out that some States may very well do an all-payer rate system which would not penalize—you don't get into discounted rates, and an open panel becomes a lot more of an option, at least those that the plan believes would satisfy the quality assurances that are necessary.

So I just point that out, that there is an effort in the plan to deal with that type of arbitrary restriction, hoping consumers would then choose the plans in which they will get the type of services that they need.

Ms. QUATANNENS. Well, as professionals. I think we would very much like to be involved in putting those together so that it comes jointly, shall we say, from the government's end and ours.

Mr. CARDIN. Let me just comment on all the fields that you have commented on. There are many, many advantages to going to a national benefit package. You all have acknowledged that. But as you go to a national benefit package, you are not going to be selecting the most rich plans that are out there. There is going to be some compromising made as to what benefits will be available to all Americans.

And mental health, for example, we know that there are plans out there in the private marketplace that are more generous than what the President has in his model. Yet there are many plans that are less generous.

I am somewhat concerned by the testimony on mental health as to whether we are moving forward or backwards in your perception of what the President has included in his package.

Do you see this as an improvement, maybe not as far as you would like to see? Or do you see it actually as perhaps setting back mental health services because it rewards more costly care rather than the community-based services that you are referring to?

Ms. QUATANNENS. I would have to give that a mixed answer. I see it as an improvement in some areas. And it certainly is a more

comprehensive package so that everything is there. Some elements that weren't there originally, like rehabilitative services. Now have been put in.

But I think that it is in the outpatient area that it is almost like they got it wrong again. They turned it upside-down, that there are incentives for hospitalization and higher cost care.

If you look at what is happening every place else in medicine, as much as can be done is done on an outpatient basis these days to cut the costs. So why, in this area, have they done it just the other way around?

Mr. WELCH. I would like to echo those comments, Mr. Chairman. And I think the danger—it is wonderful what the administration has done in emphasizing mental health and the needs for it. And to us in the field, it would be a tragedy if we design a system—and we have got all kinds of experience in the private sector where if you don't have access to the outpatient treatment, people then go into the very expensive inpatient treatment, and it drives up the cost.

There are studies now that estimate that as high as 40 percent of private psychiatric hospital admissions are inappropriate, and the insurance incentives are such that people can either pay for the cost of their outpatient care out of pocket themselves because there is no benefit for intensive outpatient treatment, or they go into \$1,000 a day hospitals that are fully paid for by their insurance company.

And if you have got an acting out adolescent son or daughter, you also get 30 or 60 days of respite care yourself.

So the incentive systems are awfully important in this area. So and I really want to emphasize, I support the benefits that are in there. Those are good things. But they have got to have the added feature. Otherwise your cost becomes prohibitive.

Mr. TOWNE. Mr. Chairman, if I may also add a point about the rehab services that are included in the plan, even though they are stipulated and we certainly congratulate the President for stating that rehab services of PT, OT, and speech will be included, there is no assurance that those will indeed be utilized.

I think that is one of the things that we see as a real question in what is going to happen. There is no stipulation that they will be utilized. And our past experience has been that when there is a gatekeeper that is going to ration out care, our experience has been that that care will be rationed to a point where we may or may not be utilized at all, or we may be utilized in a very minimal level. And then they will, then, turn around and say, well, it doesn't work. Well, we can't work if we don't have the opportunity to see the patient in a time frame which makes sense for the condition that we are dealing with.

The other point that I was trying to make about the gatekeeper is that this, indeed, will be a regressive move if, in the 30 States already where we have practice—without referral, we are now required by the plan to go back to a referral mechanism.

Physical therapists in outpatient settings are doing a very commendable job of dealing with musculoskeletal and other types of conditions without referral, which is a very costly additional point

in the activity. And we would like not to have to regress back to that point.

Ms. BURT. If I might just comment briefly in terms of laboratory, although the President's draft leaked proposal doesn't go into as much detail on inpatient and outpatient services, in fact if the program implements a competitive bidding program, there will—for laboratory services, there will, by necessity, have to be extensive exclusions such in the area of long-term care where clinical laboratories in the outpatient setting now provide 24-hour, 7-day-a-week emergency stat results.

The alternative will be a \$135 for an ambulance to transport the patient to an inpatient setting where they will probably spend a day or two overnight in the emergency room with the Medicare program to be billed four, five or possibly six times the costs of current laboratory services under the existing Medicare plan.

Mr. CARDIN. Well, let me thank Ms. Williamson.

Ms. WILLIAMSON. Could I just make another comment, in relation to the mental health benefits, that many employers offer in-house employee assistance programs which would also probably be discontinued under a system that did not have some financial incentive for continuing them.

And these are very effective in dealing with short-term, crisis-type situations. Many times they go no further than three or four counseling sessions in the workplace. And that would be an added cost that would have to go outside the system. The other thing I would like to comment on is in relation to the ability of nonphysician providers to compete, I think that the issues of quality and outcomes are very important, and we really have to look at those.

But it is extremely important that there be a range of people involved in determining what is quality and what are desirable outcomes. Because if the outcomes are framed in very medical terms or very medically oriented outcomes, then you will certainly have the bias toward the physician provider or the medical model for whatever you are dealing with.

Mr. CARDIN. Let me—Ms. Bair.

Ms. BAIR. I was just going to acknowledge what my colleague said about the gatekeeper situation and denying access to the services, and was going to talk a little bit about community-based services in mental health and the real need for those, and to make certain that they really are included in this benefit package.

Mr. CARDIN. Well, thank you. Let me thank the panel for their testimony. And you are correct, we could talk about each one of these issues for the whole day, and we appreciate your sensitivity to our time restrictions.

Let me welcome Dr. Eric Lauf, the chairman of the house of councilors of the American College of Foot and Ankle Surgeons; John Billock, representing the American State of the Art Prosthetic Association; John Adamson, representing the Council of Community Blood Centers; and Jeffrey Burgess, president of the National Association of Portable X-Ray Providers.

Let me welcome each of you to the subcommittee.

Without objection, your entire statements will be made part of the committee records. You are free to proceed as you see fit. And we look forward to your testimony.

Dr. Lauf.

STATEMENT OF ERIC LAUF, D.P.M., CHAIRMAN, HOUSE OF COUNCILORS, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

Dr. LAUF. Thank you. Good morning.

Mr. Chairman, and members of the subcommittee, I am Eric Lauf, and I practice podiatric medicine and surgery in the Falls Church, Va. area.

Currently, I am chairman of the house of councilors at the American College of Foot and Ankle Surgeons and president of the Northern Virginia Podiatric Medical Residency Foundation. This medical residency foundation trains podiatrists in the State of Virginia and is currently sponsored by the Medical College of Virginia, National Orthopedic Hospital, Fairfax Hospital, and Georgetown University Hospital.

On behalf of the more than 3,700 members of the American College of Foot and Ankle Surgeons, I am pleased to present testimony on behalf of health care legislation pending before Congress, including the proposals of the administration.

The American College of Foot and Ankle Surgeons is an educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high-quality care for the patients with foot and ankle disorders.

To improve and advance the professional skills of its members, the American College of Foot and Ankle Surgeons presents extensive scientific and educational programs. In addition, the American College of Foot and Ankle Surgeons promotes methods to ensure high standards of surgical practice, disseminate surgical knowledge, and provides information to the general public.

At the outset of my discussion, I would like to thank the members of the committee for offering me the ability and the opportunity to speak before you. Personally, I will tell you that I am, indeed, ingratiated and humble for the opportunity to both speak before you and to be selected by my profession to speak before you.

Mr. Chairman, doctors of podiatric medicine provide the majority of foot and ankle care in this country. The American public is accustomed to receiving care from podiatric physicians and expects to be able to continue to do so under new health care system.

Therefore, we recommend that any health care plan cover all medically necessary foot and ankle care and also specifically include the services of board-qualified or board-certified podiatrists acting within the scope of their State licensure.

We believe that any health care plan should be required to include doctors of podiatric medicine as participants in the plan. This does not mean, however, that a health plan must allow every board-qualified or board-certified podiatrist in an area to participate; but there should be no overt discrimination against a specialty of medicine or class of health care providers.

We believe that Medicare provides a model both in terms of coverage of foot and ankle services, as well as the definition of physi-

cian which includes DPMs. That is not to say that Medicare provides all the answers in that there are many bureaucratic problems within the Medicare system, but its fee-for-service type orientation, providing reimbursement for the services that are provided, presents, at least in part, a model to be followed.

Cost containment is an essential part of any new health care system. We must learn to spend our dollars more effectively if we are to be able to achieve the goal of universal access without bankrupting our system and our Nation.

The American College of Foot and Ankle Surgeons is committed to developing preferred practice guidelines for foot and ankle care to help our members choose more carefully among available treatment options, thus avoiding unnecessary diagnostic and therapeutic services. We have already developed six guidelines, and five more will be produced in 1994. We believe that the end result of this process will be a more cost efficient and higher quality practice of foot and health care medicine and surgery.

We are also developing outcomes-related research protocols for the treatment of bunions, heel spurs, and a multitude of other treatment problems in our system. This will enhance both the utilization review and quality assurance mechanisms in our system. The development of these guidelines for all specialties is the key to the successful utilization of services.

As will be given to you under separate cover—and I have furnished for you—our practice guidelines that have been published by the College and have been disseminated to hospitals, managed care institutions, indemnity insurance companies, and any other individuals or organizations who seek to understand the proper utilization and practice guidelines for the performances of foot and ankle health care services.

It is our feeling that free access is essential and reimbursement for those services that are approved in an appropriate way is essential. And it is our clear feeling that the establishment and utilization of preferred practice guidelines to guide the utilization of reimbursement and the performance of skills so that there is no overutilization or excessive administration or bureaucracy are among the keys to both free access, quality of care, and the delivery of services that are medically necessary.

We must remain vigilant to assure that our efforts to save money do not lead to a reduction in the quality of medical care available. Much of podiatric medicine is practiced in the office. Our members commonly perform a variety of surgical procedures with skill and safety in an office setting.

Nonetheless, the American College of Foot and Ankle Surgeons is concerned that some offices may be inadequately equipped and staffed for surgical practice. Therefore, we have developed additional guidelines for the use of office-based surgical procedures and look forward to working with the national accrediting bodies for the broadest implementation of these standards. Such standards are essential, we believe, to firmly establish the principle that the patient's safety and medical needs always must come first, no matter the structure of the health care system.

This is being stated because we clearly know that our practice, while employing some things that involve inpatient hospitalization,

ofttimes can be performed in an office-based setting or in an outpatient surgical setting, therefore, being provided at significantly reduced cost and accelerating the rate of return of the patient to active employment, and thereby decreasing workers' compensation costs or keeping patients from being out of the work force in general.

Mr. Chairman, this concludes my testimony, and I will be glad to answer any questions that you might have for me.

Thank you.

Mr. CARDIN. Thank you.

[The prepared statement follows:]

STATEMENT OF THE
AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
HEALTH CARE REFORM LEGISLATION
PRESENTED BY: ERIC LAUF, D.P.M., FACFAS
OCTOBER 26, 1993

Mr. Chairman and Members of the Subcommittee:

I am Dr. Eric Lauf, and I practice podiatric medicine and surgery in Falls Church, Virginia. Currently I am chairman of the House of Councilors of the American College of Foot and Ankle Surgeons (ACFAS). On behalf of the more than 3,700 members of ACFAS, I am pleased to present testimony on health care reform legislation pending before Congress, including the proposals of the Administration.

ACFAS is an educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the patients with foot and ankle disorders. To improve and advance the professional skills of its members, ACFAS presents extensive scientific and education programs. In addition, ACFAS promotes methods to ensure high standards of surgical practice, disseminates surgical knowledge and provides information to the general public.

Mr. Chairman, at the outset let me thank you for the opportunity to appear today and for the time that this Subcommittee is taking to hear from many interested groups and individuals so that you will be better informed on these important issues. ACFAS looks forward to continuing to work with you on health care reform legislation. On April 22, 1993, the President of ACFAS, Dr. Lowell Scott Weil, testified on possible benefit structures in health care reform legislation. I am here today on behalf of our members and the patients they serve to again ask the Subcommittee to make certain that the basic benefit package in any health care reform legislation enacted by Congress includes all medically necessary and appropriate foot and ankle services. Such legislation should also specifically recognize the services of Doctors of Podiatric Medicine (DPMs). You already have a model to work from. Medicare is comprehensive in its coverage of foot and ankle care and also includes podiatric physicians, acting within the scope of their state licensure, within the definition of "physician". Medicare's statutory definition and coverage have provided Medicare beneficiaries easy access to foot and ankle care when needed and assured their choice of practitioner. We ask you to include this scope of coverage and this definition specifically in any health care reform legislation enacted by Congress. Research demonstrates that our services are cost effective and can return patients to full functioning in a relatively short time span.

Although we have not seen legislative language interpreting the principles announced by the President, we have had the opportunity to review the summary documents that have been released. The President, and his task force, have, we believe, taken pains to be inclusive in their coverage of health professionals acting within the scope of their state licensure. Although they do not use the Medicare definition of "physician", they have clearly tried to create an opportunity for all who are licensed to practice. However, these documents suggest that no health plan or health alliance would be required to make available the services of all licensed health professionals. We believe this leaves the door open to the elimination of DPMs as reimbursed practitioners in many parts of the country, even though foot and ankle services would be covered.

Unfortunately, our members are all too familiar with discrimination by hospitals, other physicians, insurance

companies, health maintenance organizations and managed care plans. We have worked hard to overcome these prejudices, to improve the education and skills of our members and to address concerns of utilization that may have been problematic. We do not want to see this commitment to excellence come to naught under a new health care system.

We are not asking Congress or the President to guarantee the income of every podiatric surgeon or guarantee that every DPM can participate in any and all health plans that he or she may choose. We are not afraid to compete among ourselves or with other health professionals in a new framework of health care delivery. However, we do ask to be protected from overt discrimination. Every health plan should be required to offer foot and ankle services as part of the basic benefit package and to include DPMs as providers of such services. Plans can and should be allowed to choose among providers but should not be allowed to exclude a class of providers or a particular specialty. We want the opportunity for our members to be able to compete fairly in a changing market. Our patients should continue to have comprehensive, high quality foot and ankle care.

If podiatric medicine were excluded by a health plan, patients would not have access to the full range of medically necessary and appropriate foot and ankle services. Medicare data are quite clear that DPMs provide the overwhelming majority of foot and ankle care to Medicare beneficiaries. The general population is consistent with that finding. The full participation of our profession is essential if the public is to continue to receive comprehensive foot and ankle care.

Mr. Chairman, Congress will have to determine how to allocate and manage a sensible budget for health care. It does seem likely that a nation spending nearly \$900 billion annually on health care can find ways to use this money more efficiently and effectively to the benefit of all its citizens. We believe that this is a challenge to all of us, no matter what model of health care reform is ultimately adopted, Podiatric medicine is happy to respond to that challenge. ACFAS believes that the development of practice guidelines can lead to a more effective allocation of the resources available for foot and ankle care. Accordingly, ACFAS has developed six preferred practice guidelines (PPGs) on the following list of topics: ingrown toenail, intermetatarsal neuroma, hallux valgus, hammertoe, hallux rigidus, and Tailor's bunion. Five more guidelines will be produced in 1994. Each of these PPGs is designed to identify the currently accepted best methods of practice and to encourage our members to adhere to those parameters. We believe that development of medical care guidelines by physicians is critical if we are to be able to spend limited health care dollars most effectively.

ACFAS is also actively involved in outcomes research to identify the most medically effective and cost efficient treatments for foot and ankle disorders. Three topics under review are bunion, heel pain, and metatarsal pain.

Most foot and ankle surgery is performed on an outpatient basis, with a large number of procedures being performed in the office of the podiatric surgeon. As this Committee knows, neither the PRO program in Medicare or any other utilization review program exists for office surgery. This raises concerns, many of them quite legitimate, that the quality and appropriateness of surgical services performed in the physician's office may be less than adequate. While we believe that our members adhere to high standards of practice in their office surgery, we also recognize that a system to document, substantiate and support the continuing quality would be helpful. Therefore, we have established parameters for foot and ankle surgery performed in the office to assist our members set up an office that meets

reasonable standards to assure patient safety and service quality. This has not yet moved to a formal accreditation process. However, we hope very much to cooperate with other organizations, such as the Joint Commission on Accreditation of Health Care Organizations, in this activity.

Mr. Chairman, the profession of podiatric medicine has worked long and hard to achieve the stature it has today in the health care community. We hope fervently that health care reform will not undo these gains, not only for ourselves, but most especially for the patients who depend upon our services. We believe we have outlined a way to allow our members to continue to provide their services in any new health care environment that the government should ultimately develop. We have also outlined steps now underway which could be expanded in a new health care system to maintain as high a quality of service as is possible.

Mr. Chairman this completes my testimony. I would be happy to respond to any questions that you or the Subcommittee may have.

Mr. CARDIN. Mr. Burgess.

STATEMENT OF JEFFREY BURGESS, PRESIDENT, NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS, AND PRESIDENT, BURGESS HEALTH ASSOCIATES, MIDDLETOWN, CONN.

Mr. BURGESS. Mr. Chairman, members of the subcommittee, I am Jeffrey Burgess, president of Burgess Health Associates of Middletown, Conn., and president of the National Association of Portable X-Ray Providers, a national trade association representing suppliers of portable x ray services.

It is an honor to appear here this afternoon. The NAPXP applauds the steps that Congress and the Clinton administration have taken toward the goal of universal health coverage.

We believe that whatever system Congress finally adopts should seek to pay for universal coverage as much as possible by seeing that we spend our health care dollars most cost effectively.

Because NAPXP members supply their services principally to Medicare, we will address the issue of cost-effective health care spending within the context of Medicare. But we should all bear in mind that a national health reform system will encompass other payers, too, and the lessons that Medicare has learned about cost effectiveness and market incentives should be carefully considered for national health care.

As you probably know, portable x ray suppliers are companies that bring x rays to the bedsides of elderly patients in homes or nursing homes. There are two aspects of the portable x ray service that are critical to the principle of cost-effective health care spending.

The first is that the portable x ray service provides a highly cost-effective alternative to transporting the patient in an ambulance to a hospital emergency room. We estimate conservatively that the portable x ray service costs one-third to one-fifth as much.

And in this case, what is cost effective is also quality effective. When very old, frail persons are moved out of their beds and into and out of ambulances, they often sustain fractures, contract respiratory illnesses or become disoriented and traumatized. Portable x rays, by allowing patients to stay in their own beds, spare patients these problems.

The second aspect of the portable x ray service that is critical to the principle of cost-effective health spending has to do with treatment settings. Many of the conditions that portable x rays identify, such as pneumonia, chronic obstructive pulmonary disease, and simple fractures, can be treated in a nursing home, a less costly setting than the hospital. The result, of course, is additional savings for the payer. That payer, in most cases, is Medicare.

Medicare has played a leading role in developing systems to increase the cost effectiveness of health care spending in America. These are broad-based systems, however. Our concern is that the resource-based relative value scale not paint with too broad a brush.

The RBRVS includes nonphysician portable x rays in a payment methodology designed for physician services and based on physician data. Currently the system pays too little attention to the re-

source, or cost distinction between portable x rays and physician services and, consequently, pays too little for portable x rays.

Portable x ray payment levels in 1996 will be insufficient to cover the costs of providing services in many instances. In anticipation of this reality, portable x ray suppliers are scrambling to make whatever changes they can simply to remain in business. In many cases, suppliers have already reached their limits in terms of squeezing economies out of their operations.

Consequently, the choices that remain are to cut back on services, for example, by eliminating services on nights and weekends, visiting nursing homes only on a specified schedule, cutting out services in certain localities, especially rural ones, or just going out of business.

The bottom line on cost will be a greater net outflow of Medicare dollars for ambulance services, plus a greater probability of costly hospital admissions. The bottom line on quality and access will be an increase in injuries and mental pain for patients and their families.

A relatively small amount of fine-tuning, consistent with the resource-based principle of the physician's fee schedule, including the incorporation of resource-based practice expense, could solve the problem.

For example, Medicare could establish a payment level for the portable x ray setup code, a code created to capture cost differences between portable x rays and physician x rays, that more truly reflects this difference.

Similarly, the Medicare system could restore after-hours payments to recognize the higher costs of operating at night and weekends and holidays when a substantial demand for emergency portable x rays occurs.

Medicare could also recognize that doing a portable x ray in a patient's home is more costly because of the nature of the treatment setting. These refinements, to keep suppliers in business, would cost little. The portable x ray service would still be highly cost-effective and patient-friendly. These changes would just be an outcome-oriented way of seeing that Medicare gets the biggest bang for the government's buck.

And this example illustrates how a greater focus on outcomes and cost effectiveness can benefit the whole health care system.

We thank you for the opportunity to testify today and would be pleased to answer any questions.

Mr. CARDIN. Thank you, Mr. Burgess.

[The prepared statement and attachment follow:]

STATEMENT OF THE
NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
OCTOBER 26, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: I am Jeffrey Burgess, President of Burgess Health Associates of Middletown, Connecticut and President of the National Association of Portable X-Ray Providers (NAPXP), a national trade association representing suppliers of portable x-ray services. It is an honor to appear before you this morning to discuss issues relevant to national health care reform.

The NAPXP applauds the steps that Congress and the Clinton Administration have taken toward the goal of bringing the United States into the company of industrialized nations who ensure universal health coverage for their citizens. We believe that whatever system Congress finally adopts from the many well-considered proposals now pending should seek to pay for universal coverage as much as possible by seeing that we spend our health care dollars most cost-effectively. As Mr. Vladeck said when he appeared here earlier this month, "It is the lack of rational spending in today's system, with health care costs growing at twice the rate of the domestic economy, that cannot be sustained and must be dealt with in any system of health care reform."

Because NAPXP members supply their services principally to the Medicare program, and Medicare would continue to exist under most of the pending plans, we will address the issue of cost-effective health care spending within the context of Medicare. But we should all bear in mind that a national health reform system will encompass other payors, too, and the lessons that Medicare has learned and should learn about cost-effectiveness and market incentives should be carefully considered by other payors and legislators as a comprehensive national health care system is created.

Before discussing the portable x-ray industry as a case study of these lessons, I would like to briefly give you some background about the service our members provide to elderly Americans. The portable x-ray is a relatively little-known service, although Americans are likely to become more familiar with it in the coming years as our population continues to age and long-term care coverage expands. Portable x-ray suppliers are companies that bring x-rays and EKGs to the bedsides of elderly patients in homes or nursing homes. Historically, these suppliers have been small, local, literally "Mom-and-Pop" firms run by former x-ray technicians, but during the 1990s some consolidation has occurred, adding larger, multi-state firms to the industry. Portable x-rays are performed entirely by x-ray technologists, with no physician involvement in the taking of the x-ray or the transportation of portable x-ray equipment to patients. Thus, portable x-rays are not physicians' services. (After portable x-rays are taken, the films are transported to outside, unrelated radiologists for interpretation only.)

Ninety percent or more of portable x-ray procedures are covered by Medicare. As a result, the structure of the Medicare reimbursement system has dramatic impact on the portable x-ray industry. Indeed, the way in which the incentives created by the Medicare system have affected the portable x-ray industry -- a point I will discuss later -- illustrates the enormous effect of health care reimbursement systems on market incentives.

Portable x-rays are functionally different from physicians' office x-rays and much costlier to provide. This is largely because portable x-rays entail special difficulties associated with a geriatric, infirm clientele. The technician must position the patient in his/her bed for the x-ray and in the process, often deal with senility, orthopedic frailty, deafness, incontinence or uncooperativeness. The technician must also transport the x-ray equipment to the home or nursing home and then assemble, dismantle, and reassemble it for each patient who is x-rayed. These circumstances mean that, whereas a stationary x-ray technician can take about 40 x-rays per day, a competent portable x-ray technologist can take about six to seven x-rays per day. These circumstances also require special training for the technologists who perform portable x-rays and make the job relatively unattractive by comparison to x-ray technician jobs in hospitals or physicians' offices. Consequently, it is NAPXP members' experience that portable x-ray suppliers must pay their technologists higher salaries than those paid to hospital or physicians' office technicians to compensate for the higher level of training and the disadvantageous working conditions.

There are two aspects of the portable x-ray service that are critical to the principle of cost-effective health care spending. The first is that the portable x-ray service provides a highly cost-effective alternative to the other method of providing x-rays for nursing home patients: transporting the patient in an ambulance to a hospital emergency room. We estimate conservatively that the portable x-ray service generally costs one-third to one-fifth as much as this hospital/ambulance delivery method. Attachment 1 to this testimony provides a specific cost comparison for selected states. The portable x-ray service also provides a faster turnaround of films to the attending physician than the ambulance alternative, thus speeding diagnosis and treatment of injuries.

And, in this case, what is cost-effective is also quality-effective. When very old, very frail persons are moved out of their beds and into and out of ambulances or other vehicles, they often sustain fractures. If the weather is harsh -- as it is for many months in my home state of Connecticut -- patients can get respiratory illnesses. And the many elderly patients who suffer from depression, Alzheimer's disease, or both, can become disoriented and traumatized when they are moved. Portable x-rays, by allowing patients to stay in their own beds, spare patients the physical injury and mental trauma that can occur when they are sent to the hospital. Mr. Chairman, we do not believe that saving costs necessarily requires sacrificing quality, and our service illustrates that point very well.

The second aspect of the portable x-ray service that is critical to the principle of cost-effective health spending has to do with treatment settings. Many of the conditions that portable x-rays identify, such as pneumonia, chronic obstructive pulmonary disease and simple fractures, can be treated in the nursing home. In contrast, when the same patient is x-rayed at the hospital and the same condition appears, the patient will likely be admitted to the hospital for treatment. Generally, the hospital is the more expensive treatment setting. Thus, wherever portable x-rays identify simple conditions, patients receive treatment in the nursing home setting, the one that is least costly for the payor.

That payor, in most cases, is Medicare. As everyone here knows, the legislators and regulators who shape Medicare have worked strenuously throughout the 1980s and 1990s to restrain the growth of expenditures in the Medicare system. Indeed, Medicare has pioneered the use of payment mechanisms that stress cost-effectiveness and feature incentives for efficiency. The hospital prospective payment system under Part A and the increasing use of fee schedule payment mechanisms under Part B are two examples. Additionally, Medicare has led other payors in establishing measures to combat the waste, fraud, and abuse that so unconscionably increase our nation's health care costs. Your measure to restrain physician self-referral, Mr. Chairman, is a leading example, and the NAPXP applauds the expansion of this measure to encompass radiology services in this year's budget law.

Because Medicare has played such a leading role in developing systems to increase the cost-effectiveness of health care spending in America, Medicare payment mechanisms and principles can offer a useful blueprint for any system that achieves universal health care coverage. These are broad-based systems, however. Our concern is that these systems not paint with too broad a brush. The treatment of portable x-rays under the Medicare fee schedule for "physicians' services" illustrates both the "don'ts" of using too broad a brush and the "do's" of fine-tuning to make the most rational use of a cost-constraining system in particular cases.

We do not quarrel with the concept of fee schedule payment. Indeed, we know that it has been used with considerable success in other universal coverage structures, such as Germany's all-payor system. Moreover, we heartily support the ways in which the Medicare physician's fee schedule pays attention to outcomes and the effectiveness and appropriateness of care. We support the general concept of resource-based payment, as reflected in the Resource-Based Relative Value Scale underlying the Medicare physicians' fee schedule. But we also believe strongly that, in the case of portable x-ray services, the physicians' fee schedule needs some further fine-tuning to better serve the goals of cost-effectiveness and appropriateness of care.

The "broad brush" with which the physicians' fee schedule paints portable x-ray services is this. The system includes non-physician services, such as portable x-rays, in a payment methodology designed for physicians' services and based on data concerning physicians' services. Currently, the system pays too little attention to the distinction between portable x-rays and physicians' services, and, most critically, the distinction between the different patient populations they serve.

As I mentioned earlier, the inherent difficulties entailed in dealing with the nation's growing population of very old, home-bound persons make it much more costly on a unit basis to provide a portable x-ray than to provide an x-ray to an ambulatory patient in a hospital or physician's office. In

principle, at least, the Health Care Financing Administration (HCFA) has recognized this difference in a fairly creative way. Although reimbursement for the technical component of the portable x-ray service, or the taking of the x-ray itself, is exactly the same for portable x-rays as for physicians' office x-rays, HCFA has established a unique code that is billed with every portable x-ray technical component and attempts to capture the cost difference between the two types of service. The creation of this so-called "set-up" code is an example of the fine-tuning that can be incorporated into a larger system to make it work most cost-effectively. However, the level of payment for this "set-up" code, when combined with the drop in technical component payment levels that portable x-ray suppliers will experience by full implementation in 1996, reflects the need for fine-tuning.

The payment levels that portable x-ray suppliers will confront in 1996 will, very simply, be insufficient to cover the costs of providing services in many instances. In anticipation of this reality, portable x-ray suppliers are scrambling to make whatever changes they can, simply to remain in business. In many cases, portable x-ray suppliers have already reached their limits in terms of squeezing economies out of their operations. Consequently, the choices that remain are to cut back on services so that Medicare revenues stretch the farthest. In some cases, cutting back means cutting out services on nights and weekends, when technicians must be paid overtime to work and interpreting physicians are harder to contact. Sometimes, cutting back may mean coming to nursing homes only according to a specified schedule to maximize the number of patients that can be seen at any given time. In some cases, cutting back may mean eliminating services altogether in certain localities -- such as the most rural, where driving distances and times between nursing homes are the greatest, or the most highly concentrated urban areas, where the risks of vehicle damage and theft are highest. In some cases, cutting back means going out of business in an area of the country where the business simply is no longer profitable.

The net result of all these changes will be a decline in the availability of portable x-ray services, along with an offsetting increase in the number of hospital/emergency room x-rays of nursing home and homebound patients that Medicare must pay for. The bottom line on cost will be a greater net outflow of Medicare dollars to provide necessary diagnostic radiology services to nursing home and homebound patients, plus a greater probability of costly hospital admissions to treat the conditions these radiology services identify. The bottom line on quality and access will be an increase in potential injuries for patients who have to be moved to get x-rays and increased mental pain for patients and their families when these patients have to be shifted in and out of hospitals instead of staying in the familiar environment of the home or nursing home.

I might add that data from the Physician Payment Review Commission (PPRC) suggests that there may be an access problem already. Data in the PPRC's 1993 report to Congress on access to care demonstrate that portable x-rays and other "routine diagnostic radiology" services are among only two categories of physicians' services that did not increase in volume after the imposition of the physicians' fee schedule. The average across all services for quantity of care per beneficiary increased 5.2% from 1991 to 1992. In contrast, "routine diagnostic radiology," including portable x-rays, dropped 6.6% in quantity of care per beneficiary during that period. PPRC, Report No. 93-2, Monitoring Access of Medicare Beneficiaries (June 4, 1993) at 15, Table 2-1.

Significantly, PPRC research also reveals "cause for concern" about reductions in access to care for that population group most typically served by portable x-ray providers: the "oldest old (those over 85)." *Id.* at 23. The PPRC's June 4, 1993 Report states:

The Oldest Old. Patterns of service use by the oldest old (those over age 85) may also generate some cause for concern. The differentials between the oldest old and the remainder of the beneficiary population show a series of new lows for total use of services, primary care services, and selected other categories of services, including high-tech services, electrocardiograms (EKGs), cataract surgery, and radiology. (Emphasis added.)

Id. Notably, portable x-ray suppliers provide both EKGs and radiology procedures, primarily to the "oldest old."

And much of this is occurring because the Medicare system has not taken enough steps to recognize the cost-benefits of portable x-ray service and the enhanced patient outcomes it can provide. The challenge for Medicare here is to walk the line between overpaying for portable x-ray services, on

the one hand, and paying so little that there are insufficient incentives for the service to meet the needs of the growing population of institutionalized and home-bound elderly patients.

A relatively small amount of fine-tuning, consistent with the resource-based payment principle of the physicians' fee schedule, could solve the problem and consequently allow the Medicare system to reap the full benefits in cost-effectiveness and quality care that the portable x-ray service offers. Overall, if, as seems likely, the physicians' fee schedule moves to a resource-based practice expense system, the unique practice expenses of portable x-ray suppliers must be taken into account. More specifically, consistent with the concept of a fully resource-based system, Medicare could establish a payment level for the portable x-ray "set-up" code that is more truly commensurate with the difference in cost involved in providing this service versus a physician's office x-ray. Similarly, the Medicare system could restore "after-hours" payments to recognize the higher costs of operating at nights and on weekends, when a substantial demand for emergency portable x-rays occurs.

Medicare could also recognize the fact that doing a portable x-ray in a patient's home is more costly because of the nature of the treatment setting. In a nursing home, trained staff are available to help the portable x-ray technician by explaining to the patient what is about to happen and assisting the technician to position the patient. In the home, these staff are not present, and therefore, most suppliers find it necessary to send two technicians to patients' homes, in contrast to only one technician for the nursing home. The Clinton plan incorporates measures to expand the use of home and community care, based on the view that home care is more desirable for patients and their families. In fact, in the last year or so, our members have seen a marked increase in the proportion of their work represented by home care. As I have said, portable x-rays cost more to provide in the home -- but the Medicare system currently does not recognize this fact. Again, the problem could be solved -- and the system could become more truly resource-based -- through the simple addition of a home-care code.

What we are talking about here, Mr. Chairman, are relatively minor changes that represent very small expenditures. These changes would conform to the resource-based principle of the fee schedule and provide the same equity and fine-tuning that is provided to physicians, for example, through existing codes that recognize unusual complications in surgical services and extra time required for anesthesia. Refining the Medicare payment system so that the distinct nature of the portable x-ray service is adequately recognized and there are adequate incentives to permit suppliers to remain in business will not alter the fact that the portable x-ray service is extremely cost-effective with respect to the alternative. Making such changes would simply be an outcome-oriented way of seeing that the Medicare system gets the biggest bang for the government's buck. And this example illustrates the benefits that a greater focus on outcomes and cost-effectiveness can bring for the entire health care system.

We thank you for the opportunity to testify today.

COMPARISON OF MEDICARE PORTABLE X-RAY
PAYMENTS & AMBULANCE/HOSPITAL X-RAY CHARGES
SELECTED LOCALITIES
1990

LOCALITY	ROUNDTrip AMBULANCE ^{c/}	EMERG. ROOM	RAD. DEPT. (X-RAY)	PHYS. FEES (RAD. AND/OR EMERG. RM.)	TOTAL HOSP.	PORTABLE X-RAY	PORT. X-RAY INTERP.	TOTAL PORT. X-RAY	AMB. PORT. X-RAY
Tarzana, CA	302.00	135.00	86.50 ^{a/}	150.00	673.50	104.16 ^{a/} , ^{d/}	N/A	104.16	6.47
Plantation, FL	400.00	59.00	90.00 ^{a/}	50.00	599.00	90.25 ^{a/}	13.74	103.99	5.76
Tamerc, Davis, Plantation, Coral Springs, Hollywood, Margate, Sunrise, Hallandale, Cooper City and Lauder Hill, FL (2 hospitals)	306.00	59.50	120.00 ^{b/}	65.00	550.50	90.25 ^{b/}	13.74	103.99	5.29
Clearwater, FL	306.00	102.65	115.00 ^{b/}	115.00	638.65	90.25 ^{b/}	13.74	103.99	6.14
Clearwater, FL	270.00	96.50	80.15 ^{b/}	83.15	529.80	85.99 ^{b/}	13.14	99.13	5.34
St. Petersburg/ Tampa, FL	314.40	31.07 ^{d/}	98.72 ^{a/} , ^{d/}	N/A	444.19	98.09 ^{a/}	N/A	98.09	4.53
Miami, FL	352.00	156.67 ^{d/}	99.00 ^{a/} , ^{d/}	N/A	607.67	98.09 ^{a/}	N/A	98.09	6.19
Boston, MA	299.00	100.00	127.00 ^{b/}	13.64	539.64	163.64 ^{b/}	11.18	174.82	3.09
Quincy, MA	318.12	84.00	61.75 ^{b/}	13.74	477.61	163.64 ^{b/}	11.18	174.82	2.73
Lima, OH	318.00	75.00 ^{d/}	64.85 ^{a/} , ^{d/}	N/A	457.85	97.46 ^{a/}	N/A	97.46	4.70
Cleveland, OH	268.00	93.80 ^{d/}	68.28 ^{a/} , ^{d/}	N/A	430.08	97.01 ^{a/}	N/A	97.01	4.41
Central OH	226.00	54.95 ^{d/}	65.50 ^{a/} , ^{d/}	N/A	346.45	95.28 ^{a/}	N/A	95.28	3.64
Dayton, OH	238.00	32.18	55.63 ^{a/} , ^{d/}	N/A	325.81	98.04 ^{a/}	N/A	98.04	3.32
Newport, RI	176.58	69.00	13.06 ^{a/}	12.44	271.11	99.44 ^{a/} , ^{d/}	N/A	99.44	2.71

^{a/} Chest x-ray

^{b/} Hip x-ray

^{c/} Excludes oxygen fee; assumes 6-mi. round trip

^{d/} Average of area hospitals

^{e/} Global billing

Mr. CARDIN. Let me just point out that there is a vote on the floor at this point. I expect that Congressman McDermott will be here momentarily, so the committee will stay in very brief recess. And we will reconvene very shortly to continue the testimony. I am sorry for the interruption, but we can't schedule votes.

[Recess].

Mr. McDERMOTT [presiding]. In the tradition of the smooth running of the House, a new chairman appears.

Dr. Adamson, why don't you begin.

STATEMENT OF JOHN ADAMSON, M.D., PRESIDENT, NEW YORK BLOOD CENTER, ON BEHALF OF COUNCIL OF COMMUNITY BLOOD CENTERS

Dr. ADAMSON. Mr. Chairman, I am Dr. John Adamson, president of the New York Blood Center, an organization which provides blood and related services to more than 18 million people in the greater New York metropolitan area.

My blood center is also a member of the Council of Community Blood Centers, or CCBC, an association of independent community blood centers.

CCBC represents nearly 80 percent of the blood and related services provided by non-Red Cross community blood centers. Our members collect all of their blood for transfusion from unpaid voluntary donors.

Blood centers are unique, not-for-profit community service organizations which are the stewards for the blood provided by altruistic volunteers and people wanting to donate for their own use.

Blood centers also provide over 40 percent of the Nation's tissue services. We recruit the vast majority of volunteers who donate bone marrow for transplantation of unrelated recipients. We are on the leading edge of many research therapies that promise to improve the success of bone marrow transplantation and cancer therapy. Many of our centers are providers of unique and highly complex diagnostic services within their communities.

And, finally, blood centers are engaged in a broad range of educational activities at little or no cost to the public, reinforcing our not-for-profit status.

We encourage health care reform and believe such reform should preserve and build on our role in providing efficient and effective community services.

I would like to present CCBC's initial comments and concerns on the draft of President Clinton's American Health Security Act. More detailed written comments have been submitted for the record.

First, CCBC supports the inclusion of blood services under the President's proposed basic health benefits package. Outpatient, home, and community-based services should be covered when performed by blood centers on direct orders from physicians or other health professionals.

Second, CCBC supports funding for research into new medical technologies. Investigational treatments performed by community blood centers should be covered under any new health care reform system.

Third, blood centers must have the flexibility to adjust prices to reflect any increased operating costs imposed by virtue of compliance with new regulatory requirements. Any price and premium control provisions must allow for flexibility in the face of increased regulatory burdens.

Fourth, CCBC supports the President's preliminary proposals to reform medical malpractice laws.

And, finally, we also support easing regulations implemented under the 1988 Clinical Laboratories Improvement Amendments.

As more details of the President's legislative proposals for reform are made available, CCBC would hope to submit additional comments. We want to work with your subcommittee and its staff to continue to explore how community blood centers will fit into the framework of health care reform.

Until that time, Mr. Chairman, I thank you for the opportunity to present testimony this afternoon and the subcommittee for its consideration of these issues.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

Testimony of the Council of Community Blood Centers
by John Adamson, MD
President of the New York Blood Center

Mr. Chairman and distinguished members of the subcommittee, I am Dr. John Adamson, president of the New York Blood Center, which serves the transfusion needs of the 18 million people in greater New York, northeast New Jersey and the Hudson Valley. My blood center is also a member of the Council of Community Blood Centers, also known as CCBC, an association of independent community blood centers which are not part of the Red Cross network. CCBC is proud to represent nearly 80 percent of the blood and related services provided by non-Red Cross community blood centers. Our members collect all their blood for transfusion from unremunerated voluntary donors.

I am pleased to be here today to present CCBC's initial comments and concerns on the draft of President Clinton's American Health Security Act. Because the legislative language specifying the details of the proposal has not yet been revealed, my comments today are necessarily preliminary and are based on the basic principles central to the reform plan, as outlined by the administration.

I first would like to set the foundation for my comments by describing the role our blood centers play in the healthcare system. In many ways we are the embodiment of the high-quality, efficient and cost effective healthcare providers envisioned by the President's plan. Blood centers are unique and indispensable not-for-profit community service organizations which are the stewards for nearly 90 percent of the blood provided by altruistic volunteers and by people wanting to donate for their own use. Blood centers also provide over 40 percent of the nation's tissue services. We recruit the vast majority of volunteers who make bone marrow transplants outside of their immediate families. We are on the leading edge of many research therapies, such a stem cell collection and processing, that promises to improve the success rate of bone marrow transplants and cancer therapy. Many of our centers are providers of unique and highly complex diagnostic services within their communities. Finally, blood centers are engaged in a broad range of educational activities and provide operational community benefits at little or no cost to the public which reinforce our not-for-profit status.

We believe that healthcare reform should preserve and build on our role in providing efficient and effective community services. Under a reformed healthcare system, blood centers could become an even more integral part of the value chain of regional healthcare. For example, we could actually expand the range of services we provide so that we are involved at every stage of blood distribution -- from donors to recipients - saving millions of dollars in transfusion costs and improving safety by applying our state-of-the-art tracking systems to assure the right patient gets the right blood. Blood centers have also demonstrated time-after-time that we can provide a variety of therapeutic and diagnostic services with the same high quality as currently is available from other providers, and more cost-effectively than if multiple providers are duplicating services.

In the past, legislation involving certain aspects of health care has inadvertently overlooked blood centers. As a result, certain unintended consequences have adversely affected community blood centers, and, therefore, threatened vital services provided in the public's interest. I hope that any efforts to reform the healthcare system will take into consideration blood centers' unique role and allow us to provide even more efficient and dependable services to the individuals and communities relying upon our skill and products. We intend to carefully

examine the President's legislative proposal and work with Congress and the administration to assure that blood centers can continue to be models of community health services.

I would like now to address specific ways in which the President's proposed reform plan could have an enormous impact on blood centers.

Blood Services Coverage for All Individuals

CCBC supports the inclusion of blood services under the President's proposed basic health benefits package. Consequently, outpatient, home and community-based services should be covered when performed by blood centers on direct orders from physicians or other health professionals.

Blood is unique in that it is considered as both a biological service and a drug. Because the administration's proposal expands Medicare outpatient benefits to cover prescription drugs, Congress should specifically consider including blood and blood transfusions as part of any new Medicare drug benefits. However, due to the not-for-profit nature of community blood centers, blood should continue to be excluded from drug rebate requirements, consistent with current Medicare practice for inpatient care.

Protection of Medical Innovation and Research

CCBC supports funding for research into new medical technologies. Investigational treatments performed by community blood centers (e.g., stem cell collection and therapeutic hemapheresis) should be covered under a new healthcare reform system.

Further, CCBC supports inclusion of a new funding mechanism to support federally-funded medical innovation and research, such as transfusion medicine research to improve the safety of the blood supply.

Cost Containment/Price Flexibility

CCBC is vitally concerned that under a reformed healthcare system, should new tests be mandated or new FDA, CDC or alliance regulatory requirements be put in place, blood centers must have the flexibility to adjust prices (e.g., for blood components, tissues and new biologicals) to reflect any increased operating costs imposed by virtue of compliance with such new regulatory requirements. Thus, while we support President Clinton's commitment to healthcare cost containment, we request clarification and protection. Any price and premium control provisions must allow for flexibility in the face of increased regulatory burdens.

Optimizing the Role of Blood Centers as Vital Health Providers

Many aspects of the President's plan would alleviate some of the regulatory and paperwork burdens faced by community blood centers and allow us to augment the services we provide to blood recipients and healthcare providers. Specifically, CCBC supports the President's preliminary proposals to:

- * Reform medical malpractice to require alternative dispute resolution, certificates of merit, and demonstration projects for enterprise liability and practice parameters. As providers of professional services, blood centers should specifically be included in any medical malpractice reform provisions.

- * Preempt state laws limiting the scope of practice of healthcare professionals. Blood centers would like to see all such artificial barriers removed for blood center professionals and operations. We are confident these reforms will increase our efficiency without compromising effectiveness.
- * Ease regulations implemented under the 1988 Clinical Laboratories Improvement Amendments (CLIA) to alleviate the regulatory burden on laboratories. CCBC actively supports the President's recommendations to exempt more tests from CLIA regulations, grandfather current lab technicians who do not meet CLIA personnel standards for certification and training, and streamline laboratory inspections.
- * Reform antitrust laws to remove barriers to collaborative arrangements between healthcare providers. CCBC supports protections for blood center joint ventures and purchasing arrangements.
- * Institute standardized medical forms and reimbursement procedures. To increase efficiency, blood centers would like to be able to use standardized forms and claim procedures when performing applicable services.

While we strongly support the previously mentioned reforms, CCBC is concerned that some of the provisions in the President's plan could pose new regulatory burdens and impede efficient delivery of community blood services.

First, we would like to see current federal exemptions for blood centers remain intact should the plan universally expand Medicare and Medicaid anti-kickback and self-referral restrictions. This subcommittee especially knows that not-for-profit blood centers do not abuse the practice of "self-referrals" and therefore have not been a target of previous legislative efforts.

CCBC is also concerned that restricting healthcare alliances from crossing state lines might have unintended, and adverse, consequences for community blood centers. At this preliminary stage, it is unclear how such restrictions could affect blood centers operating in several states. CCBC urges that any legislation provide necessary flexibility that would encourage multi-state operations of providers.

In addition, blood centers commend the administration's commitment to quality management and consumer input. However, we believe it is critical that the Food and Drug Administration (FDA) maintain statutory and state-of-the-art safety authority over blood collection and processing regulation by preempting state and local regulations.

Finally, as more details of the President's legislative proposals for reform are made available, CCBC may wish to submit additional comments and concerns. For example, to cite just one area, as the issues relating to non-profit organizations receive further consideration, we look forward to the opportunity to consult with you. We want to work with your subcommittee and its staff to continue to explore how community blood centers will fit in the framework of healthcare reform.

Until that time, Mr. Chairman, I thank you and the subcommittee for your consideration of the issues we have brought before you today.

Mr. McDERMOTT. Mr. Billock.

**STATEMENT OF JOHN N. BILLOCK, C.P.O., COCHAIRMAN,
STEERING COMMITTEE, AMERICAN STATE OF THE ART
PROSTHETIC ASSOCIATION**

Mr. BILLOCK. Mr. Chairman, my name is John Billock. I am a health care provider of orthotic and prosthetic services and am credentialed by the American Board for Certification in Orthotics and Prosthetics (ABC).

I am here representing my profession on behalf of the American State of the Art Prosthetic Association, a nonprofit organization concerned with the coverage and quality care issues facing our Nation's 2 million amputees and millions of other individuals with physical disabilities.

Orthotics and prosthetics (O&P) are very specialized allied health care services that involve a unique blend of medicine and engineering sciences in which O&P providers are responsible for designing, developing, and fitting custom-made devices known as orthoses and prostheses. More specifically, orthoses are orthopedic braces, and prostheses are artificial limbs.

These devices are intended to meet the challenges individuals with physical disabilities face as a result of injury, disease, or amputation.

O&P services are critical to the health and well-being of disabled persons and, for example, allow persons to walk again following a stroke or leg amputation. I personally am a walking example of these vital services as I am an amputee who lost my left foot at the age of two in a farm accident but have been able to pursue my career in prosthetics and orthotics as a result of my prosthesis. I am only one example, however, of millions of positive outcomes that are a direct result of quality orthotic and prosthetic health care.

With respect to the President's plan for health care reform, we believe that this Nation has a historic opportunity to comprehensively reform our health care system that must not be missed. Too many of our fellow citizens are unable to access the quality health care they need when they need it the most. Health care proposals that do not contemplate universal coverage of a standard package of benefits within the next few years simply do not go far enough in terms of reform.

We must build on our current system with an employer mandate, with appropriate subsidies for small business and low-income persons and significantly alter current insurance practices which impede access and quality health care services. We also strongly support annual limits on out-of-pocket medical expenses.

The coverage and quality concerns regarding O&P health care, which we believe Congress must address, are as follows: With respect to coverage, we encourage maintaining a comprehensive benefit package that includes orthotic and prosthetic health care.

We encourage coverage of replacement prosthetic and orthotic devices for reasons other than changes in physical condition as currently stated in the Clinton plan. We encourage that the "custom devices" limitation should not apply to orthotic and prosthetic serv-

ices since O&P is truly customized to each individual with a disability.

We also believe that O&P health care must be regulated separately from DME, durable medical equipment, because there are distinct differences between the two.

With respect to the issues of quality, we must create managed care standards which preserve quality O&P health care. These standards must combat incentives for underservice. Risk adjustments must adequately compensate for the true cost of specialized care. O&P consumers must have a broad selection of appropriately accredited O&P practitioners in managed care and other types of plans.

The concern we have in this regard is that there are currently only 2,800 certified prosthetists and orthotists throughout this country. Because of this, O&P consumers must have the ability to go outside their network of care to assess appropriate services without financial penalty.

Lastly, we do not believe that competitive bidding should be applied to O&P health care because it will immediately encourage reduced quality due to the unusual and unpredictable nature of physical disabilities and the fact that O&P health care is a labor intensive service.

Mr. Chairman, I thank you for the opportunity to address this subcommittee.

[The prepared statement follows:]

TESTIMONY OF
THE AMERICAN STATE OF THE ART PROSTHETIC ASSOCIATION

PRESENTED BY JOHN N. BILLOCK, C.P.O.

Distinguished Chairman and Members of the Subcommittee:

My name is John Billock and today I address this Subcommittee on behalf of the American State of the Art Prosthetic Association (ASOTAPA), a national non-profit organization comprised of prosthetic and orthotic practitioners who design, fit, and fabricate artificial limbs (prostheses) and orthopedic braces (orthoses) for this nation's two million amputees and millions of people with physical disabilities. Although ASOTAPA is primarily a provider organization, we are very supportive of the prosthetic and orthotic consumers' health care reform agenda represented by the Amputee Coalition of America which testified before this Subcommittee last Spring on the issue of the basic benefit package.

This commitment to the prosthetic and orthotic consumer can be seen in the fact that ASOTAPA's current president and general counsel, Peter Thomas, is a consumer of two artificial limbs. I also use an artificial limb and can personally testify to the great advancements that have been made in the fields of orthotics and prosthetics in the recent past. I received my prosthetic and orthotic education at Northwestern University Medical School and became certified to practice prosthetics in 1970 and orthotics in 1972. Professionally, I co-chair ASOTAPA's government relations committee, I serve on the Advisory Board for the Amputee Coalition of America (ACA), and I am a Past-President of the American Academy of Orthotists and Prosthetists (AAOP).

During my 23-year career, I have provided prosthetic and orthotic treatment to thousands of amputees and others with physical disabilities and receive a great deal of personal satisfaction from seeing the improvements in mobility that good prosthetic and orthotic care can bring. Quality prosthetic and orthotic care can virtually neutralize the disabling effects of physical impairments and maximize an individual's ability to function at the job, in school, and in the home. The cost effectiveness of good prosthetic and orthotic care cannot be understated. A recent study conducted by the University of Miami School of Medicine found that a \$6,000 investment in a functional, modern artificial limb saves an estimated \$430,000 over a five year period in medical expenses due to other debilitating complications, lost productivity, and government income maintenance, to say nothing of the quality of life.

I. The Specialized Nature of Prosthetics and Orthotics:

Prosthetics and orthotics are often inappropriately considered under the broader category of durable medical equipment (DME). Unfortunately, this has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. Quality prosthetic and orthotic care is as much a professional service as it is a device that results from this service. All prostheses and most orthoses are custom designed and fit to the particular medical and functional needs of the patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes, and complex contours, is fundamentally different from most types of durable medical equipment and should be treated separately from DME in legislation and in regulation.

In addition, significant variations exist in the delivery of quality prosthetic and orthotic services, primarily due to the explosion in technology over the past decade. The prosthetic and orthotic profession has a defined body of clinical and technical knowledge and a core of 2,800 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities. These factors justify specialized treatment for prosthetic and orthotic services in health care reform legislation. Before we explore these issues in the context of President Clinton's health care reform proposal, however, let us state our general view of alternative approaches to national health care reform.

II. Comprehensive Reform Includes Universal Coverage:

ASOTAPA believes that this nation has a historic opportunity to comprehensively reform our health care system that must not be missed. Too many of our fellow citizens are unable to access the quality health care they need when they need it most. We must not let partisanship or pride in authorship of particular proposals impede the goal of better health care for all Americans. ASOTAPA believes that aspects of several proposals have great merit, but is committed to the goal of universal coverage. Health care proposals that do not contemplate universal coverage of a standard package of benefits within the next few years simply do not go far enough in terms of reform. We must build on our current system with an employer mandate, with appropriate subsidies, and significantly alter current insurance practices which impede access and quality of health care services. We also strongly support annual limits on out-of-pocket medical expenses.

We applaud the Clinton Administration for its enormous effort and commitment to comprehensive national health care reform. We also applaud the Members and staff of this Subcommittee for their health care reform efforts and look forward to working with you in the coming year to pass legislation that fixes the problems but retains best aspects of our health care delivery system.

III. Orthotic and Prosthetic Priorities Under the Clinton Plan:

ASOTAPA believes that the Clinton Plan, as currently understood, represents the most comprehensive and viable approach to accomplishing the goals of universal coverage, increased access and enhanced quality of health care services. Overall, the Clinton Plan has the potential to greatly enhance health care for people with mental and physical disabilities. The prosthetic and orthotic community, however, has several areas of concern in the two general areas of coverage and quality that we would like to see addressed in the Congress.

A. Coverage:

Maintaining a Comprehensive Benefit Package.

A comprehensive standard benefit package is critical to the success of a reformed health care system under the Clinton Plan. As pressure mounts in Congress to limit the cost of health care reform, ASOTAPA urges the Members of this Subcommittee to resist efforts to limit the nature, scope, and duration of the Clinton Plan's standard benefit package. Prosthetics and orthotics are currently included as standard benefits in the Administration's proposal. According to the September 7 draft of the Clinton Plan, "leg, arm, back and neck braces, artificial legs, arms and eyes" including "replacements if required due to a change in physical condition" are included as standard benefits. Training for the use of prostheses and orthoses is also included which recognizes one aspect of the service component of prosthetic and orthotic care.

Replacements of Prostheses and Orthoses.

Many private insurance policies currently do not cover replacements of prostheses and orthoses. This results in the absurd situation where an amputee, for instance, is expected to function on one artificial limb per lifetime, with no regard to age, growth, changes in medical or functional needs, simple wear and tear or significant advancements in technology. The draft language of the Clinton Plan effectively eliminates this unscrupulous practice whenever a change in a person's physical condition exists. ASOTAPA believes that prosthetic and orthotic replacements should also be covered as a standard benefit due to normal wear and tear and if advancements in technology have the strong potential to improve prosthetic and orthotic outcomes.

The Limitation On "Custom Devices":

The draft of the Clinton Plan, unfortunately, does not draw a distinction between durable medical equipment and prosthetics and orthotics in the proposal. Both of these areas are addressed in the same section of the draft plan. The limitation that the standard benefit package "does not include custom devices" seems to apply to both DME and prosthetics and orthotics. This is likely a classic example of the confusion and misunderstanding which leads to the non-recognition of prosthetics and orthotics as separate and distinct from durable medical equipment. All prostheses and most orthoses are custom devices by definition. Therefore, if this language were to apply to prosthetics and orthotics, it would negate coverage of these services as a standard benefit. We cannot imagine that this was the intent of the Administration's drafters.

If the Clinton health care reform legislation is consistent with the draft proposal, ASOTAPA strongly urges the deletion of the limitation of customized devices as it may apply to prosthetic and orthotic devices, but also as it applies to durable medical equipment as well. If this limitation were to apply to prosthetics and orthotics, it could be interpreted by insurance companies to mean that a generic version of a typical prosthetic or orthotic device would be covered as a standard benefit, but "add-ons" or "customization" would be considered an uncovered expense. This interpretation would be devastating to prosthetic and orthotic consumers and practitioners.

B. Quality:

Quality Care Under Capitated Health Plans:

Under the Clinton Plan, every employer would be required to offer three different types of health plans to their employees; an HMO-type plan, a PPO-type plan, and a fee-for-service plan, with varying levels of premiums, co-payments, and deductibles. There would be an open enrollment period each year for consumers to switch from one plan to another if they are not satisfied with the level of care. This would afford many Americans with greater choice than they now have to choose the type of plan that suits their needs. ASOTAPA is very concerned, however, that the Clinton Plan's heavy reliance on managed care will result in compromised quality of prosthetic and orthotic care. Because the health insurance industry is heading toward greater use of managed care on its own account, the health care reform debate is an excellent opportunity to establish industry standards that will both hold down costs and preserve the quality of health care in managed care arrangements.

Simply stated, capitated health care delivery systems create great incentives to underserve participants in the plan, particularly individuals needing specialized or expensive health care services. Presumably, a risk adjustment mechanism will attempt to compensate health plans for high-cost users of care. If this risk adjustment does not adequately reflect and account for the true costs of care for specialized or costly services, health plans will have an incentive to develop a poor reputation for servicing the needs of these populations, so as not to attract additional participants requiring these services. It is critical that any prospective risk adjustment is set at levels that adequately compensate health plans for the true costs of specialized services to all participants in a plan, but particularly to individuals with disabilities.

Selection of Qualified Orthotic and Prosthetic Practitioners:

An alarming trend in managed care is that health networks are contracting with one or two prosthetic and orthotic providers in a geographical region in order to achieve efficiency and bulk purchasing power. This often disrupts long-standing patient-practitioner relationships and does not adequately recognize the specialized nature of prosthetic and orthotic services. A decrease in quality care and patient satisfaction is often the result. In order to ensure quality prosthetic and orthotic care in capitated health care plans, each plan should be required to offer a wide selection of qualified prosthetists and orthotists who are certified to practice in accredited facilities. Because of the specialized nature of these services and to protect health care consumers, the credentialing body for these functions must be the American Board for Certification in Orthotics and Prosthetics.

Health plans should also be required to cover prosthetic and orthotic services from qualified providers outside of a plan's geographical area, especially if the practitioner is willing to provide the service at an equivalent fee of a provider within the plan's geographic area. A prosthetic or orthotic consumer should not be required to exhaust every provider within the network before being able to access care outside of the network. This practice is wasteful and costly. This requirement is justified by the specialized nature and individuality of prosthetic and orthotic services, the expertise of which often lies in different states and regions of the country.

Competitive Bidding Should Not Apply to Prosthetics and Orthotics:

In order to achieve Medicare savings, the Clinton draft proposal states that competitive bidding would be utilized for certain Part B services. Due to the highly specialized and customized nature of prosthetic and orthotic services, competitive bidding for these services would directly and immediately result in a decrease in quality. Standard items and off-the-shelf devices lend themselves more readily to competitive bidding because providers can compete based on efficiency of their business operation. This is not the case with customized devices. Lesser quality services and lesser functional devices will be the inevitable and immediate result of competitive bidding in the provision of prosthetics and orthotics, whether it be in the Medicare program or in private health plans.

Mr. McDERMOTT. Thank you all very much.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

And thank you all, gentlemen, for your testimony. I am sorry I was not here to hear all of it. I looked over some of it as I could. It seems to me that the thrust of what you are saying, though, is: Include us; make sure we don't get overlooked in this basic benefit package and in this managed care operation. And I understand your concerns.

I happen to favor a completely different approach to health care reform, as does Mr. McDermott, I think, to the Clinton plan. Although Mr. McDermott and I are probably on opposite sides of the Clinton plan, if the Clinton plan were in the middle.

But my thinking is, why should we, up here in Washington, determine who is included and who is not included in some theoretical, one-size-fits-all plan?

My preference is to change the Tax Code to give people the incentive to use their health care dollars wisely by setting up medical savings accounts which are tax deductible and allowing them to choose what they use that money for. If they use it at all, and then provide deductions for employers and exclusions for employees for a large deductible insurance policy—which is true insurance—and not simply prepay for a lot of things that we know people are going to use, and take away any current deduction in the Tax Code for first dollar coverage insurance. Such insurance was a creature of World War II, basically when we were trying to find a substitute for wages.

I would be interested in your comments from your perspective as to whether you think changing the incentives in the system to allow people to spend their own dollars for health care, for basic health care, and then have say a \$3,000 deductible insurance policy for those things that are unforeseen. Would this be a wise approach compared to the Clinton plan or by itself.

Any comments that you would make would be welcome.

Dr. LAUF. I think it is a—I think it is difficult to anticipate some of the costs in the health care system as regards to providing of care that will be necessary and needed by any one patient at any one given time.

So to specifically budget that through taxes is something that obviously you researched to a great degree and obviously have formulated opinions on it. As regards to the current system that exists, it is the platform of the American College of Foot and Ankle Surgeons that, within the system that exists currently right now, through over utilization in some cases, the lack of preferred practice guidelines, lack of utilization review, and lack of quality assurance proactive guidelines to administrator rendering of care, combined by excessive administrative and bureaucratic type of policies within the health care insurance companies, billions of dollars are expended that do not go to the direct care of the patient currently.

So if that could be employed with the concepts that you are proposing, I think you would find even a greater pool of money is available than that which currently exists to be utilized for the providing of health care.

And, therefore, free access can be ensured to patients for the delivery of health care and guidelines followed in practice, preferred practice guidelines, so that before the—before the care is actually rendered, all parties have understood and clear how those guidelines are to be followed for the rendering of that care.

Mr. BURGESS. I guess I have to say that coming from where I am sitting, we are at somewhat of a disadvantage in that most of our patients are probably—the average age is about 75 years old. And although in some cases they are able to determine the route by which their money is spent, in many cases, they are not able to make that determination and/or were faced with an acute situation where treatment takes place. And then afterward we learn who is actually going to be the payer. So it is a decision that I would like to see our patients be able to make. But, clinically, it is just not possible.

Dr. ADAMSON. I have a slightly different perspective in that the gentlemen around me are practicing and providing different kinds of service than a very large community-based service such as the New York Blood Center. And then we, as a member of an association of independent blood centers throughout the United States.

We look at cost savings that might be implemented through an altered form of health care or a reformed health care system in a slightly different fashion. We are providers of product, a very complex product, as you are all very aware, both considered a biological and a drug, and we must go through the process of obtaining, testing, inventory management, and distributing that product to a population base which exceeds 18 million people. And we serve over 250 hospitals at our center alone. It is an extremely complex procedure and one in which we work very closely with the Food and Drug Administration.

But we see opportunities for savings. We see opportunities for better access to health care delivery in a variety of ways. Home transfusion services, which are not always reimbursed, would save a national health plan substantially. The ability to provide a product that has been, if you will, value enhanced by the removal of certain materials such as leukocytes in the transfusion setting which reduces sensitizations and complications of subsequent transfusions.

I guess what I am saying—and I know that the Council of Community Blood Centers has not formulated a policy on comparative plans—is that as an individual, I think that there are enormous opportunities for us all. And I also think that there are needs, particularly in a very large complex community such as New York City, that must to be met. We would welcome any and all improvements to the health care plan.

Mr. BILLOCK. The cost of health care obviously is of major concern to all of us, and our organization has not distinctly made decisions regarding any one of the plans that have been proposed.

However, the Clinton plan does mention orthotic and prosthetic health care whereas we have not seen that mentioned in the other plans. That obviously is a concern that I would have. Of major importance are the issues of universal coverage and the issue of pre-existing conditions and how these exclude people from care. For example, in my practice I have had amputees who lost their pros-

thetic health care coverage because they changed from one plan to another. This has particularly been a problem for parents with young children born with congenital limb deficiencies and with the absence of an arm.

And in a case like this, we have several families now who have no coverage for prosthetic health care as their child grows and develops into their teens and adulthood.

Another issue that is affected by this, as well as with respect to the coverage, is that some carriers are only paying for one prosthesis per lifetime. And even for an individual who is an adult, fully grown, it is almost ludicrous to think that that person will never require another prosthesis, and that it will never wear out. It is a mechanical device and it can be a electromechanical device, just as the car is that we drive around in every day. It needs to be maintained, serviced, repaired, and eventually replaced.

Thank you.

Mr. McDERMOTT. Thank you.

Dr. Adamson, I have only one question. I read your testimony and I recognize the burden of paperwork and CLIA and all the other things that people put on you. But I wonder, how do you interface with the whole issue of AIDS and people's worry about the blood supply and still have some kind of national standards? How do you lessen that burden?

Dr. ADAMSON. That kind of—that kind of burden, Mr. McDermott, we would not want to see made less. We fully support commissioner Kessler's demand for good manufacturing practices in the testing of blood and blood products.

They have become more complex as you know, because we—blood centers such as ours and all of the centers in the community, the Council of Community Blood Centers—are now being held to higher, more strict standards. And we agree with those.

We believe that the initiative that has been announced by the Commissioner, the requirement that centers such as ours have quality assurance and quality control activities which stand independent of operations, as good manufacturing practices require, is a good initiative. They do, however, have to be recognized as adding cost to the operations of a center such as ours.

How we are affected by CLIA is in a slightly different fashion. To give you perhaps the most obvious example, we have highly skilled technicians who would not qualify for supervisory positions under CLIA, because of not having had a certain number of years of formal education. We believe that the suggestion to grandfather those senior and very capable technicians under the CLIA regulations is desirable and, in our center, would be a very positive outcome.

Mr. McDERMOTT. So if I can quote from your testimony, it says, "ease regulations implemented under the 1988 CLIA amendments to alleviate the regulatory burden on laboratories."

That is what you are talking about?

Dr. ADAMSON. For the New York Blood Center, that is what I am talking about. That is correct.

Mr. McDERMOTT. All right. Thank you very much.

Thank you all of you for coming. It helps us to have wide views of the health care providers in this country when we try to write these laws. Thank you.

Mr. McDERMOTT. The next panel, Richard Doherty of the National Association of Medical Equipment Services; David Williams, of Invacare Corp. of Elyria, Ohio; and John Wren of the National Association of Nutrition and Aging Services Programs.

And I know you thought we would never get to you. As you know, your entire testimony will be entered without objection into the record. So, if you wish to summarize or talk about other things beyond what is in your written testimony, please feel free to do that.

Mr. Doherty.

STATEMENT OF RICHARD DOHERTY, PRESIDENT, COMPREHENSIVE HOME HEALTH CO., AVON, MASS., AND CHAIRMAN, NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

Mr. DOHERTY. Thank you, Mr. Chairman, members of the committee. My name is Richard Doherty. I am the president of Comprehensive Home Health Co. in Massachusetts, a provider of home medical equipment services. And I am presently chairman of NAMES, the National Association for Medical Equipment Services.

NAMES and the home medical equipment services industry applaud the Clinton administration and Congress for tackling the difficult problem of trying to reform our Nation's health care payment system and for placing health care reform at the top of our Nation's agenda.

The administration has properly included home medical equipment as part of the standard benefits package in its health security plan. This should be no great surprise since home care, including home medical equipment services, is demonstrably cost effective, even more so than similar care provided in the more costly institutional setting.

Equally important, in 1991, the American Association of Retired Persons' study found that 3 out of 4 older Americans would rather provide care for a disabled, frail, or elderly relative or friend at home rather than have to admit that person to a nursing home.

But the following three key items are not currently part of the Clinton administration's plan, and they should be: One, custom home medical equipment devices and rehabilitation technology. Such equipment should be covered.

xxTwo, freedom of choice guarantees. All Americans should be allowed to select their care providers, including home medical equipment suppliers.

And, three, quality of care assurances. Quality should be measured in a way that is consistent with existing home medical equipment industry practices. This would include the service component, customization, patient satisfaction, and success of outcomes.

Unfortunately, the administration's basic benefits package does not provide coverage for custom devices. Customized rehabilitation technology such as specialized wheelchairs and seating systems is an essential for persons with disabilities as properly fitting a pros-

thetic device is for an amputee, while prescribing the correct drug medication dosage is for a specific illness.

We cannot forget that a wheelchair is the only means by which some individuals are mobile. Wheelchairs are, in a sense, their legs. Especially important, all Americans should have freedom to choose their health care providers. The administration's proposal encourages health plans to operate as efficiently and cost effectively as possible. This could allow health plans to contract with only one provider in a given field. Such a practice, however, would limit the choices of available providers which consumers can select.

The administration's proposal would allow consumers to choose health plans based on price and quality. Because quality measurement and determination are such important issues NAMES proposes that only tested methods of quality assurance and quality improvement be used.

Finally, comprehensive health care reform should establish no impediments either to the provision of home medical equipment services or to the enhancement of care in the home and other noninstitutional settings.

The National Association for Medical Equipment Services and the entire home medical equipment industry is prepared to help in any way we can as Congress debates health care reform. I would be happy to take any questions.

Thank you.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]



Testimony
 of
 Richard Doherty, President
 Comprehensive Home Health Company
 Avon, Massachusetts
 and
 Representing the
 National Association for Medical Equipment Services
 on
 National Health Care Reform
 before the
 Subcommittee on Health
 House Ways and Means Committee
 Hearing
 of
 October 26, 1993

Mr. Chairman and Members of the Committee: I am pleased to testify on behalf of the National Association for Medical Equipment Services (NAMES), the only national association representing the home medical equipment (HME) services industry exclusively. The HME services industry provides quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Clinton Administration and Congress for tackling the difficult problem of trying to reform our nation's health care payment system and for placing health care reform at the top of our nation's agenda. We appreciate the opportunity to testify on this historic proposal and acknowledge the House Ways and Means Committee's efforts to begin hearings so promptly. NAMES, which represents more than 2000 HME suppliers, many of whom are local business leaders, pledges to do its part to work with Congress and the Administration to help pass an equitable national health care reform plan before the close of the 103rd Congress.

The Administration properly included HME as part of the "standard benefits package" in its Health Security Plan. This should be no great surprise, since home care including HME services is demonstrably cost-effective — even more so than similar care provided in a more costly institutional setting. A 1991 Lewin study compared the costs of home care using HME versus hospital care for three diagnoses: hip fractures, amyotrophic lateral sclerosis (ALS) with pneumonia, and chronic obstructive pulmonary disease (COPD). The study found that home care using HME resulted in cost savings of between \$300 and \$2,300 per patient episode. When multiplied by the prevalence of each illness, the potential annual savings per year was estimated at \$575 million for hip fractures alone.

The HME services industry does not refute the important role of institutions for many individuals' medical care. Nonetheless, advances in equipment have increased to the point where people now can safely be discharged by their physicians sooner from acute care facilities. Because high quality services can be provided in the home by a competent HME supplier, the need to ensure that HME remains available in the future by requiring it as a covered benefit is of paramount importance.

Equally important, consumers far prefer to recuperate from an illness or injury at home. A 1991 American Association of Retired Persons (AARP) study found that nearly 3 out of 4 older Americans would rather provide care for a disabled, frail or elderly relative or friend at home, rather than have to admit that person to a nursing home. NAMES 1991 "Coming Home" study revealed identical results. Thus, including HME as an enumerated benefit in any national health care plan makes ultimate sense for the elderly and the millions of Americans with disabilities, as well as those who may become disabled or ill in the future.

Including HME services as a basic benefit also is consistent with general practice in the health insurance field. For example, the overwhelming number (almost 87%) of federally qualified health maintenance organizations (HMOs) include HME as a standard benefit in their health care packages. This reflects a clear awareness among HMOs that HME is an integral component of the nation's health care system. Most of the top twenty major private health insurance providers also currently offer HME as a basic benefit. Additionally, the Consortium for Citizens with Disabilities (CCD), a well-respected coalition of individuals and diverse organizations representing people with disabilities, specifically recommended that "durable medical equipment and other assistive devices" be included in the standard benefits package.

There are a number of factors that have contributed to the growth in recent years of home care — and specifically HME services. Some of these reasons are relatively evident even by casual observation. Our nation's elderly population is increasing rapidly; while 31 million Americans were 65 years of age or older in 1989, this figure is expected to more than double to 69 million by 2050. The number of older Americans will cause a continuing increase in individuals with chronic health care problems, thus increasing the demand for home care services. This is in addition to the greater number of acute care patients served by the HME services industry directly as a result of earlier institutional discharges due to the "quicker and sicker" phenomenon. As a result of this phenomenon, increasingly HME is required by patients who are discharged from hospitals while in the acute stage of illness.

The rise in home care services is not merely confined to the elderly. For example, the development of sophisticated home medical equipment has enabled parents to have their children who need life-supporting devices such as ventilators, apnea monitors or parenteral and enteral nutrition therapies remain at home for the particular care needed. Current trends evidencing higher survival rates for premature infants portend an increasing reliance on alternative health care delivery methods, such as HME, which allow infants and children to recuperate and be cared for in the home.

NAMES is equally pleased that the Administration's proposal acknowledges the importance of the service component in providing HME, by specifying "training" as a covered benefit. Service is an essential aspect of the provision of quality home care using HME — HME services can and do prevent further deterioration of preexisting conditions. Far too often, however, the provision of quality services is not recognized in reimbursement mechanisms. Recognition of the training aspect of providing HME services to Americans is long overdue and highly welcomed.

Significantly, however, the following three key items currently are not a part of the Administration's plan, but should be:

- "Custom" home medical equipment devices and rehabilitation technology coverage — such equipment also should be included in the standard benefits package;
- "Freedom of choice" guarantees — all Americans should be allowed to select their own health care provider, including HME suppliers; and
- "Quality of care" assurances — should be measured in a way that is consistent with existing HME industry practices. This would include: the service component; customization; patient/client satisfaction; and success of outcomes.

NAMES is extremely concerned that the Administration's basic benefits package does not provide coverage for "custom devices." Customization of HME and rehabilitation/assistive technology, such as specialized wheelchairs and seating systems, is as essential for persons with disabilities as properly fitting a prosthetic device is for an amputee or prescribing the correct drug medication dosage is for a specific illness.

Many people with severe disabilities now survive accidents or injuries which would not have been possible even in the recent past. As a result, some HME suppliers, known as rehabilitation technology suppliers (RTSs), have begun to specialize in the area of providing custom-designed rehabilitation equipment to individuals with severe neurological impairment. Such advances in equipment allows people who would heretofore have been confined to institutions for the remainder of their lives to lead productive lives with the assistance of rehab equipment.

Too often, we forget that a wheelchair is the only means by which some individuals are mobile — wheelchairs are, in a sense, their "legs." Noted the Amputee Coalition of America: "A customized wheelchair or seating system for a permanent wheelchair user is, in effect, no different from an individually designed and fitted socket of an artificial limb." In not covering custom devices, the Clinton plan essentially tells physicians that a customized fit designed to meet the medical needs of their patients is no longer important. We respectfully disagree.

Custom devices also prevent deterioration and complications in the health status of patients. An AARP *Consumers' Wheelchair Product Report* (1990) agreed with this assertion:

"At best, an ill-fitting chair is uncomfortable. At worst it causes bruises, poor posture, pressure sores, and limits mobility....Insist on being measured and fitted with your cushion, if you have one, before you take any chair home. It only requires a few minutes and it's critical to your comfort and safety."

Restrictions on customization thus could lead to aggravating an existing disability, while causing additional expense for the patient/client and the overall health system. Without custom devices, the quality of life for persons with disabilities would be greatly diminished — this especially runs counter to the goals of the Americans with Disabilities Act (ADA).

Especially important, all Americans should have freedom to choose their health care providers. The Administration's proposal encourages health plans to operate as efficiently and cost-effectively as possible. This objective, while laudable, could allow health plans to contract only with one provider in a given field. Such a practice, however, would limit the choices of available providers from which consumers can select. And, as such, HME suppliers from whom consumers may have received care in the past or whose companies are closer to home could be closed out.

NAMES already is beginning to see situations develop where consumer choice is being severely limited because some HMOs will contract only with one HME supplier. Our concern is that reducing the number of providers in a given field will result in decreased competition, eventually driving up prices, while diminishing quality of care. No single provider can adequately cover as large a geographical and populated area as envisioned in the Clinton plan. Suppliers also vigorously oppose the concept of a competitive bidding system for HME items that essentially would lead to diminution of services and quality.

NAMES recommends that the final health care reform legislation should provide incentives for health plans to contract with as many providers as necessary to meet the needs of the community. At the very least, there should not be any disincentives in the system to allowing full provider participation. As well, administrative simplification of forms and the processing of reimbursement claims would help eliminate some of these disincentives.

The Administration's proposal would allow consumers to choose health plans based on price and quality. Because quality measurement and determination are such important issues, NAMES proposes that only tested methods of quality assurance and quality improvement be used. These methods might include requiring a full range of HME services available, outcome measures, as well as patient satisfaction. Providers and consumers alike should have substantial input on determining or defining quality.

In the midst of the current health care reform debate, the one solution to rising costs that presents itself as an efficient, affordable and compassionate viable option is HME services as part of home care. HME suppliers meet the needs of a wide range of individuals who require medical equipment and services in their homes. Suppliers not only provide many of the more "traditional" items of equipment such as those envisioned when the Part B "DME" benefit was first adopted as part of the Medicare law in 1965, but now we also provide a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, and advanced rehabilitation equipment. Comprehensive health care reform should establish no impediments to the use of home care and HME services that are currently available or to the enhancement of care in the home and other non-institutional settings.

NAMES and HME suppliers are ready to assist Congress in any way possible as you debate national health care reform, especially through providing additional information on the HME services industry's three concerns described above. I will be pleased to answer any questions you may have. Thank you.

Mr. McDERMOTT. Mr. Williams.

**STATEMENT OF DAVID T. WILLIAMS, CORPORATE DIRECTOR
OF COMMUNICATIONS AND PUBLIC/GOVERNMENT
RELATIONS, INVACARE CORP., ELYRIA, OHIO**

Mr. WILLIAMS. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to be here today. And I want to start by extending an apology to the committee staff because I was a little late in getting my written statement in. But I see that they got it. So I won't read it, and that will be good for all of you.

I represent Invacare Corp. which is the world's leading manufacturer of home medical equipment. We manufacture many of the products that Mr. Doherty and other home medical equipment providers then transfer on, through either sales or rental, to end users.

We are very strong proponents, of course, of home care for a lot of reasons that Mr. Doherty mentioned. But I think my perspective of home care and my advocacy for it is unique and that it comes from three perspectives.

I had the experience in 1978 of becoming a consumer of home care services. I am living proof of the old adage that disability is the only equal opportunity minority. I went from riding bicycle 100 miles a week and serving as president of my professional organization to receiving SSDI and being functionally, at that time, a quadriplegic. I didn't recover in the long-term care facility. Matter of fact, after 9 months there, it was give-up time. It was only when I got home, surrounded by family and friends and people who really cared about me, that I began my recovery. And I think I have come back a long way, from a taxuser to a taxpayer.

The second perspective I have is that of a provider. Working for Invacare Corp. we hear daily about the difference that home care makes in people's lives, how it takes people from isolation, loneliness, and poverty, into integration, warm lifestyle, and productivity.

And, finally, I am seeing home care more recently in a different light and that is as the home care overseer. I am 1 of 13 children—a good Catholic family—and my father's favorite T-shirt says on the front, get even with your kids, live long enough to be a problem to them.

I am currently overseeing my father's home care. He has chronic respiratory disease, and he has an oxygen concentrator and receives his medication through nebulizer compressor at home.

I can tell you from firsthand experience that it would cost this country—because my father's disability is service-connected—it would cost this country in excess of \$2,300 a month to care for him in a nursing home operated by the Veterans Administration. We are currently spending around \$400 a month. So we can talk about costs; we can talk about outcomes. I feel them, and I see them every day. That is where my advocacy for home care comes from.

I would like to take the opportunity to talk about a couple things unrelated to health care reform but I think that are harbingers of gloom on the horizon.

I think this committee needs to be warned that there is a tremendous disconnect between what the Congress and the White

House are talking about when it comes to health care reform, and what is going on at the Health Care Financing Administration in Baltimore.

No one who is serious about health care reform is ignoring the issue of paperwork reduction. No one who is serious about health care reform is talking about limiting people's choice. And no one who is serious about health care reform is saying anything about preserving the status quo and the bureaucracy. But that is what is happening.

In a program that is currently underway at HCFA, physicians who are prescribing home medical equipment, according to an article that was published in part B News, an independent publication, yesterday, physicians are being presented with 10 new forms to fill out when they prescribe home medical equipment.

These aren't included in my testimony, but I brought copies for the staff to distribute. These are a couple of the forms that you are going to have to fill out as a physician.

And if I am correct, Mr. McDermott, you are familiar with physician forms. Are you willing to sign a form for a patient receiving home medical equipment that says that you will personally vouch that the electrical circuitry in their home is capable of handling the current demands of that equipment? As a physician in today's litigious society, would you testify to the structural integrity of a home? It is asked for on these forms.

Limiting choice. Mr. Doherty mentioned the fact that custom equipment—people think about customized wheelchairs and custom home medical equipment as if it were luxuries. It is not. I sit in a custom chair. It costs \$2,200. Except for the fact that I would pay \$300 for this fancy paint job, everything else on it is functional. It is customized because I happened to be six foot two before I became four foot six, and it had to be built to accommodate my leg size. It is custom because the back's lower to provide me more mobility because my injury is lower. It is custom because it fits my lifestyle. And to look at that and say it is a luxury is not accurate.

But right now at HCFA, they are saying we want plain vanilla and nothing beyond plain vanilla. And if, by the way, you want something beyond plain vanilla, you can't involve us in paying for it; you will pay for the whole price up front, and we may or may not reimburse what is allowable for the plain vanilla. That is unacceptable. They are limiting choice. And they are institutionalizing a bureaucracy in a way that I am not sure that this Congress is aware of.

This whole durable medical equipment regional carrier program has been implemented without benefit of public comment. There have been no publications of the new national coverage guidelines in the Federal Register. But yet this is going on, and this is defining how home medical equipment will be in the future.

The last thing I wanted to touch on, and I will just do it quickly—is to mention, as Mr. Doherty said, the importance of allowing people to upgrade equipment within any type of payment system.

I know that there is no reasonable way for me to go and expect my insurance carrier or public carrier to pay the \$300 for a fancy paint job. But that shouldn't limit me from having that fancy paint job. If I can pay for it myself, if I am willing to pay for it, if I have

family or friends that are willing to pay for it, to make my life richer, why should I not have that opportunity?

But right now, upgrades are not permitted under Medicare, and we are worried that they won't be permitted under a reformed system.

Senator Daschle did get an upgrade bill introduced and passed in the Senate last year, but it ran out of time and didn't go through the House. We ask that this committee take the lead and maybe bring this issue back up before the Congress, now, to institutionalize the concept of upgrade so that it gets included in reform down the road.

Thank you for the opportunity to share these comments with you. Myself and Invacare are ready to give information and assistance to any member that should you call.

And if you want to learn more about the home medical equipment industry, I would invite you to give me a call and come up; and we will have you tour our plants and see what home medical equipment is all about.

Thank you.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

TESTIMONY OF DAVID T. WILLIAMS INVACARE CORPORATION

Good morning, Mr. Chairman and members of the Committee. My name is Dave Williams and I am Corporate Director of Communications and Public/Government Relations for Invacare Corporation. I want to express my gratitude to the Committee for providing this opportunity to make sure that home care is part of the dialogue on health care reform. We support the President's inclusion of home care services and equipment in the standard benefits package. (Mal Nixon's letter to the President is attached.)

For those of you who do not know Invacare, we are the world's leading manufacturer and distributor of home medical equipment and mobility aids for people with disabilities. We manufacture wheelchairs, ambulatory aids, home care beds, respiratory devices and bathroom safety products, among other things. Our headquarters are in Elyria, Ohio (outside Cleveland), but we also have plants in Florida, California, Canada, Mexico, Great Britain, Germany and France. In addition to the various countries where we have local operations, there are roughly 60 other countries to which we export our products.

This Congress and the Administration have been given a tremendous assignment by the American people. You have been told to "reform" our health care system and find a way to extend its benefits to the 37 million people who have no health insurance. At the same time, you have been directed to reduce the costs of health care. While these charges may seem in direct conflict, that need not be the case. I am here because Invacare, as a leader in the home care industry, is committed to helping policy makers understand that home care can be a tool that proves useful in accomplishing the mission before you. Hopefully, my testimony will provide you with some background on home care and stimulate your curiosity to look further at this means of providing cost effective, clinically appropriate health care. We believe that, when you do, you will arrive at the inescapable conclusion that home care must be part of any standard benefit package arising from the current debate on health care reform. We know that as you look for ways to reduce health care costs, you will recognize that home care can help you achieve that objective. We are confident that as you learn more about today's home care, you will come to see it as an appropriate tool for addressing both chronic and acute health care needs.

Let me start by providing you with a snap-shot of today's home care. Home care is equipment such as manual and power wheelchairs, walkers, patient lifts, oxygen concentrators and numerous other items that make it possible for people to deal with illness, injury, disability or chronic health conditions in their home surrounded by family and friends. Home care is trained health care professionals providing services like physical therapy, respiratory care, intravenous therapy, nursing services and home maker assistance in such a way as to equal or exceed the level and quality of services in facilities like hospitals and nursing homes.

Home care is clinically appropriate health care that often yields better patient outcomes than facility based services. Home care is excellent health care delivered in an environment that patients prefer at a fraction of the cost of facility-based care.

Invacare's message will focus on the inseparable linkage between current financial and medical trends affecting home health care and demographic trends affecting older Americans, citizens with disabilities and health care consumers in general.

There are dozens of trends, and they're all swirling at once like a tornado. But there are a few major ones that clearly show why future domestic policy should favor home care. These trends include:

- slow population growth and an aging population;
- rising health care costs;
- inadequate access to health care;
- and issues relating to the quality of health care (including its outcome and delivery).

For many of you this will be a review, but let's start by looking at rising costs. In 1970, U.S. health expenditures were \$74.4 billion. Since then, those costs have grown at an annual rate of 11.6%, nearly three percentage points faster than our gross domestic product (GDP), to a total figure that approached \$700 billion in 1990.

During that same 20-year period, from 1970 to 1990, health care consumer pricing increased 400%. That's pretty hefty when you consider that the aggregate consumer price index increased 250%, heftier still knowing that median wages increased only 200% during that time. Health care spending in the United States is the highest in the world. It has been growing faster than spending in other major countries, and the gap between us and other countries is widening.

Moreover, the rate of increase is accelerating. Expenditures are expected to represent more than 16% of the GDP at the turn of the century. By way of comparison, health care costs as a percent of GDP from 1970 to 1990 grew only from 5.5% to 8.1% in Germany, from 1.4% to 6.5% in Japan and from 4.5% to 6.2% in the United Kingdom. Employers in those countries obviously carry a much smaller health care burden than their American counterparts giving them a competitive advantage when it comes to the cost of labor.

Now is not the time to get into much detail about the causes of this phenomenon. In brief, over-utilization, under-utilization, lack of preventive care, and a burdensome bureaucracy have all contributed. In addition, "health care dollars" are used to subsidize the exorbitant expenditures for product liability and medical malpractice insurance made necessary by a virtual explosion in the area of health care litigation.

The inaccessibility of health care to 37 million Americans is inexcusable. Although U.S. health expenditures have grown dramatically, we have been unable to reduce the number of uninsured Americans or to substantially improve the crude health statistics for the nation's population. In fact, the percentage of people with no insurance actually increased 21% between 1978 and 1989.

Americans without any type of health insurance defy stereotypes. They represent a true cross section of the nation. Non-working adults account for only 16% of them. Nearly two-thirds of the uninsured are in families of employed workers, almost half of whom are self-employed or work for companies with less than 25 employees. Health insurance has become so expensive that many employers cannot afford to offer it.

Small wonder that the need for national health care reform has become an issue of such prominence. Indeed, it rose to the top of the public policy agenda in last fall's elections, ranking second in importance as a campaign issue with voters behind only the economy.

Now let's take a look at one of the primary consumer groups for health care in America -- older people. Americans are living longer lives than ever before. In 1776, a child born in America could expect to live only to age 35, on the average. But times have changed. Extraordinary breakthroughs in health care have eliminated many of the diseases that used to claim the lives of early settlers. Smallpox is gone. Cholera is almost nonexistent. The death rate from tuberculosis has been reduced by over 99.9%.

A child born in the U.S. today can expect to live to age 75 and a half. Government statisticians estimate that medical advances will tack on two more years by 2010. In the coming decade, the median age of the U.S. population will go from 33 years to 36 years. What does that mean? In the 1920's, one American in 25 was over the age of 65. Today, it's one in eight. By 2050, if the Census Bureau's projections are correct, almost one American in four will be eligible for Social Security under today's rules.

While the current decade will see very little change in the number of Americans aged 65-74, there will be dramatic gains in the number of those older than 74. Today's group of 10 million 75-84 year olds will grow in size by 21%. And the number of Americans who are over 85 will increase from its current number of three million by 42%.

So, not only do we have escalating national health care costs, but we also can expect a dramatic rise in the number of people who need extensive medical care. This is quite a challenge.

But there is good news in the form of patterns of change in where people, both old and young, go for their health care.

There is a shifting emphasis away from inpatient health care in the United States toward community-based ambulatory care. Hospital patients here are going home "quicker and sicker" than ever before.

The U.S. Department of Commerce reports that from 1979 to 1990, hospital inpatient admissions declined by 10%, while outpatient visits grew nearly 44%, clearly indicating this trend. Average length of hospital stay declined 11% between 1970 and 1990, but hospital and physician costs increased more than 650% during that time.

Today's health care payers are pressuring "the system," searching for medically viable, cost-effective alternatives. Employers, unions, HMOs, PPOs, insurance companies, Medicare, Medicaid and even patients themselves are all on the bandwagon calling for change.

And with the average hospital stays ranging anywhere from \$600 to \$800 per day and at-home care averaging around \$200 per day, it's no wonder that the scales are tipping in favor of home care.

Home care also offers tremendous emotional advantages to many people who benefit from the support of family members and the comfort of a familiar environment. The National Association of Medical Equipment Services (NAMES) conducted national research on peoples' attitudes about home health care. Not surprisingly, they found that three out of four Americans would prefer to be taken care of at home when recuperating from a serious accident or illness. And, lest you think the NAMES survey might be self-serving, the Governor of Ohio reported last spring that a state poll revealed that 90% of the people surveyed would prefer to receive health care in their homes.

Additionally, there has been a dramatic surge in the availability of home care services. At a time when many industries have shown declines in job growth, the U.S. Bureau of Labor Statistics reported a whopping 192% increase in jobs in the home health care industry during 1990. Industry experts estimate home health care to be a \$15 billion dollar industry with double-digit growth that is expected to continue well into the next century as those born after World War II grow older.

Advances in technology have made medical equipment and medical services more sophisticated and more widely available for home use. For example, respiratory therapy for AIDS patients and intravenous therapy that were previously available only in medical institutions are now routinely administered at home. Computerized electronic controls on power wheelchairs have allowed many people

with quadriplegia to function independently, without an attendant. Independent community home health programs that deliver a comprehensive array of home health services are expanding rapidly.

And, on a growing basis, hospitals are embracing this trend as they develop and expand quality home care services for their patients. The American Hospital Association reports that over 30% of the nation's hospitals have a home health care program, nearly three times as many as in 1980.

There are new programs taking shape in a number of innovative and exciting ways. For example, pro-active hospital discharge planning programs are becoming more sophisticated and more widespread. Hartford Hospital has a program that is an outstanding, highly organized example of how hospitals can provide continuing care and timely, achievable, quality discharge plans for patients.

There are other hospital-based home care organizations like The Cleveland Clinic Foundation, which has a home care program that, among other things, takes care of patients awaiting heart transplant surgery. Instead of leaving these patients in intensive care units at a cost of thousands of dollars a day for up to six months, care is provided in their homes. Technology enables these patients to receive intravenous antibiotics and other drugs at home to prepare them for their surgery. If necessary, home respiratory care is available and equipment designed to assist the patient and their family in a variety of ways. All this makes it possible for people awaiting transplant surgery to get care at home that meets or exceeds the quality of care they would receive in the hospital.

Clinic surgeons report that patient survival and recovery is enhanced by home care. They arrive in surgery in better spirits, with a positive attitude knowing that they can still be part of their home and family.

Another innovative model can be found at the Cooperative Care Center for New York University's Medical Center. NYU's program is characterized by a live-in family member or friend acting as a "care partner" during acute inpatient care. It has an emphasis on education, encouraging full patient and family involvement in care during the hospitalization, thereby preparing both parties for management at home after discharge.

So far, we've reviewed the soaring cost of health care in this country and the problems with lack of access to medical care due to the millions who have no health insurance. We've talked about the aging of the U.S. population. We've heard that Americans prefer to get medical care at home when it's feasible. And we've talked about the advances in home medical technologies and the pressures that exist from health care payers to reduce costs.

With all of this as background, it is clear that the importance of legislation and public policy in support of the nation's home care needs for all Americans is critical.

It is indeed disappointing that many in the Congress and Administration do not yet understand the cost-effectiveness of home care, or how it relates to the entire continuum of care. Some still view home care as additive to the already escalating health care bill. Others misunderstand home care, viewing it as an alternative only to chronic care and nursing home situations, failing to realize its viability in acute care situations.

While most home care involves chronic problems that are not life-threatening, and while this segment of home care continues to grow along with our aging population, more and more physicians at the frontiers are expanding their work to include acute, complex situations. For example, an article that appeared in the New York Times last spring talked about a six-month old infant in Chicago with severe spinal cord injuries -- who could not suck, breathe, cry, or even move on her own -- and who was discharged from a hospital intensive care unit to be at home with her family. While this particular case may be an extreme example, it nevertheless illustrates my point about the advances in home care. If this child can be served in home, think of the thousands of individuals in facility-based programs who could benefit from home nursing and advanced home medical equipment. Technology is enabling the development and rehabilitation of an acute care patient in a home care environment and the number and types of medical conditions that can be cared for in the home increase nearly every day.

Perhaps one of the reasons that many in Washington have yet to recognize the value of home care is that there has been very little empirical data produced to show its actual cost effectiveness.

One such research study was conducted by Lewin/ICF in March 1991 for three trade associations: the National Association of Medical Equipment Services (NAMES); the Health Industry Distributors Association (HIDA); and the Health Industry Manufacturers Association (HIMA). This study analyzed the cost effectiveness of hospital therapy versus home therapy under three separate medical conditions: hip fractures; Amyotrophic Lateral Sclerosis (ALS) with pneumonia; and Chronic Obstructive Pulmonary Disease (COPD).

In hip fractures, home care resulted in a dramatic average savings of \$2,300 per episode. Multiplying that by the national prevalence of 250,000 cases results in \$575 million in total annual savings which could be realized if home care were applied routinely in cases of hip fracture.

In ALS with pneumonia, the savings per episode were \$300, or \$459,000 for 1,500 cases annually.

In COPD, the savings per episode were \$520, or \$48 million dollars for 93,000 cases annually.

The Home Care Coalition -- a group representing manufacturers, dealers and direct care providers -- cites similar potential savings. They project that it would cost \$61,000 to care for an infant born with breathing and feeding problems in the hospital versus \$20,000 if cared for at home and \$23,000 for ventilator-dependent patient care in the hospital versus \$1,700 at home.

As the ongoing debate on national health care reform unfolds, government awareness will grow and public opinion will become even more focused on how home care can be part of the solution to the nation's soaring health care costs. Home care also holds much promise as a tool for helping meet the challenge of providing access to health care for those currently without insurance.

Yet today, a variety of questions must be addressed in order to facilitate growth of home care. Do today's multiple, varied reimbursement systems motivate the most cost effective medical choices, or do we need to revise them? We think the answer is an obvious yes.

Is home care truly more cost effective than inpatient care? Our data shows that it is.

Are physicians available for at-home care? They must change in many ways if reform is to work and physicians may not be either the most appropriate or cost effective people to provide many home care services.

Can nurses do more than they are legally allowed to do today? If nurses were permitted to provide greater levels of care than today's laws permit, we could see a dramatic impact in the form of lowered costs and improved access.

What about the 30-40% vacancies and under-utilized overhead that exist in our nation's hospitals today? We cannot thwart progress to preserve an outdated dysfunctional system.

And finally, how can we be sure that the home care industry is capable of providing quality care and is it willing to be held as accountable as traditional care providers? We can provide a prompt and unwavering response to that question.

Invacare and the entire home care industry want Congress and the appropriate administrative agencies to stipulate strong quality outcome indicators for home care products and services. We are aware that a collective lack of knowledge about home care often translates into a lack of confidence. However, we are confident that our products and services can meet or exceed all reasonable quality indicators. Collectively, the home care industry has supported every effort to rid our nation of the very few unscrupulous equipment vendors and service providers who engage in fraudulent or abusive activities.

The industry was on record as supporting the fraud and abuse provisions contained in H.R. 11 which was vetoed by President Bush last November and we support the provisions contained in H.R. 21, introduced by Chairman Rostenkowski this year. We believe that strong, clear and enforceable quality indicators can be one more tool in the effort to combat fraud and abuse in the home care industry.

Before concluding this testimony, I would like to make brief comments on four important issues. First, I want to urge that Congress use extreme caution and consider the impact of certain cost containment practices from the manufacturer's perspective. Then I want to offer observations on the apparent disconnect between the goals of health care reform and new systems being implemented as we speak by the Health Care Financing Administration (HCFA). Finally I want to add a consumer perspective on the issue of choice as it pertains to home medical equipment under current and proposed reimbursement programs.

There has been a lot of talk about capping expenditures and freezing prices as a means of reining in the costs of health care. As you consider these options, please remember the impact that such measures can have on a company like Invacare. Congress has the ability to cap Medicare and Medicaid payments for specific items and history has shown that private insurers follow your lead. But such measures fail to take into account the costs of manufacturing.

Invacare cannot control what our suppliers charge us and our employees rightfully expect that their wages remain competitive and keep pace with inflation. Price freezes and spending caps on manufactured goods are penny wise and pound foolish. While they may hold some attraction for short-term cost reductions, they could result in job reductions at medical equipment manufacturers and enable off-shore companies to take bigger market shares from American companies. Worse yet, prolonged price freezes or artificial spending caps that do not take into account the impact of inflation on manufacturing costs could force some manufacturers to relocate plants outside the United States. Congress must be very thoughtful and evaluate the actual long term benefits of such actions and acknowledge the very real possibility that price freezes on medical equipment could inflict a serious blow on the health of several American companies and therefore, the U.S. economy.

The home care industry has long contended that red tape and huge bureaucracies are a significant cause of the high cost of health care. Several small Invacare dealers report that they spend as much as 30% of their time on insurance forms and Medicare reports. Two of our largest multi-state dealers state that 20% of their employees work full time in the billing and collection department. Reducing some of the redundant reporting requirements and implementing systemic improvements, such as electronic claims processing, would make a significant contribution to any cost reduction efforts. Rather than reducing paperwork and streamlining the reimbursement process, government bureaucrats are creating new "paper mazes" that will increase costs and, I might add, consumer frustration.

HCFA is in the process of implementing a new program for processing Medicare claims for durable medical equipment. All such claims will be reviewed by four durable medical equipment regional carriers or DMERCs. The HME industry has and continues to be supportive of the DMERC system as a way standardizing claims processing and eliminating fraud and abuse by a small number of unscrupulous vendors. However, as it is being implemented, the DMERC system will slow claims processing, create more -- not less -- paperwork and further restrict access to HME and home care services.

A recent issue of Part B News, an independent publication that covers the Medicare program, carries an article about ten new forms that will have to be filed with claims for Medicare coverage of HME. At the same time, the DMERC program will require physicians to complete detailed new forms to certify the medical necessity of HME. Believe it or not, health care providers will be required to certify that the home is properly wired to handle the electrical requirements of HME and that the building is structurally sound enough to support the proper use of the equipment.

HCFA has used the transition to the DMERC process as an opportunity to impose new national coverage guidelines without going through the public review and comment processes defined in the Administrative Practice Act. As a result, new standards exist that would deny patients coverage for DME that would improve the quality of life for them and protect the health of family members who are often the primary care givers. Other new standards create new barriers to reimbursement for wheelchairs and other devices

which can best meet the unique needs of the beneficiary. Invacare urges Congress to take HCFA to task for proposing new guidelines and implementing new procedures which will serve to deny access to appropriate HME for Medicare beneficiaries.

Invacare urges Congress to act now to implement a patient upgrade provision for Medicare beneficiaries and to ensure that such a provision is part of HME coverage in any health care reform package enacted. Invacare and the HME industry accepts that budget restraints make it necessary to limit reimbursement for HME to basic "plain vanilla" models. Under current regulations, vendors cannot accept assignment under Medicare for the allowable and then work with the patient to upgrade the DME to units that best meet the needs of the patient. Our industry has sought authorization for an upgrade provision for several years. Such an upgrade provision is accepted practice in Canada, France and most of the western world. Only the Region C HME carrier currently allows an upgrade for Medicare beneficiaries. This must be changed to allow such upgrades in all four regions.

As a manufacturer of home medical equipment, Invacare encourages Congress to include coverage for home care in any standard benefit package -- and Invacare is not alone. The latest proposal of the Jackson Hole Group for designing the Initial Uniform Effective Health Benefit Plan (March, 1993) includes a recommendation that coverage for home care services and equipment be part of every American's basic health care benefits. While HME is "covered" under Medicare and Medicaid, Congress must learn from past practices that have denied access to technology that can ameliorate the effects of illness or disability to many people in the name of cost containment.

While the initial outlay for state-of-the-art technology may seem high, experience has proven time and time again that these are wise investments. Still, current Medicare regulations discourage consumers from "upgrading" to the best equipment by supplementing the Medicare allowable with their own resources. The HME industry has sought the opportunity to conduct a pilot demonstration concerning this type of "patient choice program" but has been repeatedly rebuffed by the HCFA bureaucracy. Hopefully, any HME coverage adopted as part of the current national reform effort will be written in such a way as to insure access to appropriate technology and permit upgrades where appropriate for all Americans.

In closing, one might ask how national policy reform can address the immense challenges at hand of improving health care coverage for the nation's 37 million uninsured people while simultaneously reducing its health care costs that have risen more than 75% in the past five years? Home care is, at least in part, an important answer to that question.

There was a time in this country when home care was commonplace. Family doctors made routine house calls, delivered babies, set broken bones and treated pneumonia in people's homes. If health care reform is to succeed in providing coverage to uninsured Americans and reducing costs, home care will be returning, albeit in a very different light, to these roots.

Thus it is now incumbent on Congress to accept President Clinton's recommendation and make certain that home care is a key component of any standard benefit package enacted in the 103rd Congress. As the debate continues, please be assured that Invacare Corporation stands ready to work with Congress and the Administration to provide any information and assistance.

Thank you for the opportunity to present our views. I would be pleased to respond to any questions.



September 17, 1993

The President
The White House
Washington, DC 20500

Dear Mr President

On behalf of Invacare Corporation and the home care industry, I want to thank you for the opportunities you have provided us to present our views on health care and in particular, the opportunity to review your comprehensive health care reform proposal. Invacare is the world's leading manufacturer and distributor of home medical equipment (HME) with over 3,400 employees worldwide and 1993 sales expected to top \$370 million.

I am impressed with your level of understanding of the role home health care can play in increasing access to health care while reducing costs. It is clear you understand that home health care is a viable alternative to facility-based care for both acute and long-term care. From your record in Arkansas and the emphasis on home care in the proposed American Health Security Act, it is clear that you know that 70% of Americans polled state that they would rather recover from an accident or illness in their home. It is also clear you understand that, in many cases, home care can yield clinical outcomes equal to or better than facility-based care.

I have reviewed the *working group draft* of the plan and am most appreciative of the fact that you have included both home health care services and HME as covered items in the basic benefits package which will be the central focus of the American Health Security Act of 1993. I believe you have proposed meaningful reform that is good for America and with the inclusion of coverage for home care services and HME, your plan can meet the twin objectives of reducing costs while insuring access to health care for every American.

Many arguments will be mounted in opposition to your proposal and I am sure that one of them will be a projected adverse impact on employment. Those who would make this argument have lost sight of the growth potential for home care. The demand for nurses, therapists and aides to provide home health services is already high and it will increase if your plan is adopted. As home health care is made available to the 37 million uninsured Americans and home care is extended to others as a covered long-term care option, businesses like Invacare will continue to grow and create jobs in the U.S.A.

Mr President, I truly believe that the basic benefits package you will propose to Congress next week as part of the American Health Security Act will be good for America and Americans, and I am willing to publicly express my support for this package in whatever way you may find appropriate. Toward that end, I would like to extend an invitation to you and Mrs. Clinton to visit Invacare either at our world headquarters in Elyria, Ohio or at our major manufacturing facility in Sanford, Florida. These would be great venues to speak about your support of home care and the reasons why you have included it in your basic benefits package.

I also serve on the Board of Directors and Executive Committee of The Cleveland Clinic Foundation, one of the most advanced health care institutions in the world. One of the fastest growing programs at The Clinic is our home care subsidiary which provides cost-effective and clinically-appropriate services to people with severe health conditions - including patients awaiting heart transplant surgery! This would be a very appropriate venue to discuss the role of home care in meeting the needs of patients with acute illness.

In closing, I want to thank you for your leadership on this important issue and congratulate your staff and the White House Task Force on Health Care Reform for a job well done. As the debate on this important issue heats up, please know that I support your basic benefits package and stand ready to articulate that support upon request.

Sincerely,

A. Malachuk, III
Chairman, President and
Chief Executive Officer

Mr. McDERMOTT. Mr. Wren.

Mr. WREN. Thank you. Good afternoon.

Mr. McDERMOTT. The vote is over in 5 minutes, so I have got about five minutes.

**STATEMENT OF JOHN WREN, IMMEDIATE PAST PRESIDENT,
NATIONAL ASSOCIATION OF NUTRITION AND AGING
SERVICES PROGRAMS**

Mr. WREN. OK. My name is John Wren, and I am the immediate past president of the National Association of Nutrition and Aging Services Programs.

I am also the executive director of the local service provider in Youngstown, Ohio, Senior Nutrition Services. We provide home-delivered meal services, congregate meal services, and medical transportation to senior citizens.

Thank you very much for inviting us to testify on the issue of health care reform and the President's plan. We applaud your efforts to sort through these complex issues and to consider the perspective of service providers.

NANASP is a membership organization representing over 1,500 direct service providers, primarily funded through the Older Americans Act. We serve approximately 3½ million older and disabled individuals and 248 million meals per year. We provide meals at 15,000 congregate designing centers and in homes in all 50 States and the Territories.

We are the primary providers of home-delivered meals to home bound elderly individuals. This is the fastest growing service in the aging community. Since the passage of the Older Americans Act in 1965, America has been at work establishing an aging network of State units on aging, area agencies on aging, and service providers to provide community-based services and programs to assist the elderly in maintaining independence and dignity.

This network represents an unparalleled resource for the delivery of health and long-term care services. The congregate meal sites serve as community focal points that older persons recognize and accept as places to go for information and services, including health, consumer and nutrition education, outreach, information and referral, transportation, socialization, and recreation, all in addition to the nutritious meals.

Congregate sites also serve, particularly in smaller rural communities, as the base of operations for home-delivered meals programs.

Today we would like to address three issues: Nutrition and its critical relationship to health care, coverage for nutrition screening and treatments under health care reform, and nutrition in community-based long-term care.

Our nearly 30 years of experience in aging network has taught us that nutrition and screening services belong in any health or long-term care initiative for all age groups.

We are very pleased to see that nutrition is mentioned in very positive ways throughout the President's health care draft plan.

NANASP wholeheartedly supports a shift in our health care focus toward prevention. We know that proper nutrition can play a significant role in the prevention and treatment of such chronic

diseases as cardiovascular diseases, cancer, kidney disease, osteoporosis, hypertension and diabetes.

Diet is implicated in 6 of 10 leading killer diseases. Nutrition is an excellent example of the major benefits of a small investment in prevention. Research shows that for every dollar spent on nutrition therapy in treating diseases and other medical conditions, a minimum of \$3.25 in later medical costs is avoided.

A recent Peter D. Hart Research Association national survey of health care providers and administrators revealed widespread malnutrition among the elderly and agreement that it could be prevented. This survey showed that malnutrition—

Mr. McDERMOTT. Mr. Wren, if I could interrupt you, I am sorry. I have to do this. We have got to go and vote so we can get back. I will go and come back. It will take us about 10 minutes.

[Recess.]

Mr. McDERMOTT. Why don't you proceed, Mr. Wren. Sorry to interrupt you in the mid-sentence; but the Congress sometimes does things on the back of a galloping horse.

So please go ahead.

Mr. WREN. Thank you. The national survey that I referred to showed that malnutrition is a serious problem affecting significant numbers of the elderly population, as much as 1 in 4, both inside and out of health care facilities. Among hospitalized elderly patients, the rate of malnutrition was estimated to be 50 percent.

The health care professionals survey strongly agreed that routine nutrition, screening, and treatment is a cost-effective way to address this crisis and that the lack of direct reimbursement is a major obstacle to providing treatment.

Many billions of dollars are spent in health care for older adults. Most, if not all, expenditures are directed at treatment of existing chronic conditions and the restoration of health and functional abilities. Such conditions can result in poor nutritional status or themselves be the result of—or be exacerbated by poor nutritional intake.

This is a direct hearing on the cost of health care, quality of life and outcomes. Good nutrition is the very basis for good health. It plays a crucial role in rehabilitation and saves health care dollars. Studies have indicated that malnourished patients have significantly higher rates of mortality, prolonged hospital stays as well as higher incidence of complications.

One study of 800 patients selected from common diagnosis related groups, DRGs, demonstrated the cost effectiveness of nutrition support, even without complications malnourished patients, cost hospitals more per patient than well-nourished patients. These additional charges were \$5,000 and \$10,000 for medical and surgical patients respectively.

Those whose nutritional status is poor have three times the number of major complications, stay in the hospital two-thirds longer, cost several thousand dollars more per hospital stay, and are three times more likely to die.

Expensive health care procedures and drug therapies cannot be a substitute or overcome profound deficits in nutrition. Comprehensive nutrition services—including meals, nutrition assessment,

counseling, case management, and shopping assistance—must be an integral part of my discussion of health care reform.

Benefits derived from a system of comprehensive community nutrition support include lessening the complexity and, therefore, the cost of treatment due to poor nutritional status, lessening of the length of hospital stays, and forestalling or foregoing client placement in nursing homes.

Established community nutrition programs must be incorporated into the broader system of health care and long-term care reform to save scarce resources and to provide services in the mode most preferred by patients.

Efforts must target those clients with chronic disease or health problems by increasing the assessment and monitoring of their nutritional status.

Capacities of community programs must be strengthened to include modified and/or therapeutic diets, multiple meals per day, and 7-day-a-week service. A unique network of nutrition providers is already in place across the country and fully expects their services to meet the need for health care reform. Such congregate and home-delivered meals programs are recognized by seniors and caregivers and are trusted and respected.

However, the capacity of the system has been limited by inadequate resources. To accomplish their role in the new health care system, programs must develop a continuum of nutrition support that should include nutrition screening, nutrition assessment, nutrition case management, that is service planning, arrangement, and followup performed as part of comprehensive case management.

They should have comprehensive meal services, that is 3 days a—three meals a day, 7 days a week, offer modified and therapeutic meals and supplements. Nutrition education, counseling and shopping assistance should also be part.

Nutrition programs must develop distinct delivery models to respond to various segments of the older population and other dependent care populations, as well as stay abreast of ongoing nutrition research in order to incorporate the most effective interventions.

But before any of this can be accomplished, we must recognize that food is medicine. Without addressing basic nutrition issues faced by most older adults, even our best efforts at treatment and medication will fail.

We must recognize that investing in nutrition support helps contain health care costs. We must encourage the use of community nutrition programs as an element in both health care and long-term care reform.

It is the old ounce of prevention adage in its truest form.

Finally, we must look to the establishment of new and/or expanded revenue streams under a revised health care system to provide these basic services to ensure that older adults receive the treatment or services which preserve their independence and dignity.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF JOHN WREN
NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS**

Good morning. My name is John Wren. I am the Immediate Past President of the National Association of Nutrition and Aging Services Programs (NANASP). Thank you very much for inviting us to testify on the issue of health care reform and the President's plan. We applaud your efforts to sort through these complex issues and to consider the perspective of service providers. We also thank you, Chairman Stark, for your many years of support for reforming the health care system.

NANASP is a membership organization representing over 1,500 direct service providers, primarily funded through the Older Americans Act (OAA). We serve approximately 3.5 million older and disabled individuals, and 248 million meals per year. We provide meals at 15,000 congregate meal sites and in homes in all 50 states and the territories. We are the primary providers of home-delivered meals to homebound elderly individuals; this is the fastest growing service in the aging community.

It is important for any new health care reform to recognize that there is an existing network of community nutrition providers. This network provides nutrition services in a cost-effective and efficient manner. Expanded nutrition treatment should build upon this network. Without specifically linking reimbursement to these established programs, the current community programs could be jeopardized.

Since passage of the OAA in 1965, America has been at work establishing an "aging network" of State Units on Aging, Area Agencies on Aging, and service providers to provide community-based services and programs to assist the elderly in maintaining independence and dignity. This network represents an unparalleled resource for the delivery of health and long-term care services.

The congregate meal sites serve as community focal points that older persons recognize and accept as places to go for information and services, including: health, consumer, and nutrition education; outreach; information and referral, transportation, socialization, and recreation - all in addition to the nutritious meals. Congregate sites also often serve, particularly in smaller rural communities, as the base of operations for home-delivered meals programs.

Today, we would like to address three issues: nutrition and its critical relationship to health care; coverage for nutrition screening and treatments under health care reform; and nutrition and community-based long-term care.

Nutrition and Health Care

Mr. Chairman, our nearly 30 years of experience in the aging network has taught us that nutrition screening and services belong in any health or long-term care initiative for all age groups. We are very pleased to see that nutrition is mentioned in very positive ways throughout the President's health care plan draft document.

NANASP wholeheartedly supports a shift in our health care focus toward prevention. We know that proper nutrition can play a significant role in the prevention and treatment of such chronic diseases as cardiovascular diseases, cancer, kidney disease, osteoporosis, hypertension, and diabetes mellitus. Further, diet is implicated in 6 of 10 leading killer diseases. The President's proposal includes, and NANASP supports, an option for health plans to cover health education and training, including nutrition counseling. NANASP believes that all plans should provide these benefits. Home health coverage for infusion therapy will also be provided under the basic benefit package. This includes both drugs and nutrients to be provided intravenously.

Nutrition is an excellent example of the major benefits of a small investment in prevention. Community nutrition programs as part of a health delivery system can decrease hospital admissions and readmissions; reduce length of stay in the hospital; forestall patient moves to more restrictive settings and reduce long-term care utilization; lessen the complexity of hospital stays as a result of malnourishment upon admission; and play important roles in rehabilitation and therapy.

Research shows that for every dollar spent on nutrition therapy in treating diseases and other medical conditions, a minimum of \$3.25 in later medical costs is avoided. A recent Peter D. Hart Research Associates national survey of health care providers and administrators, who care for America's elderly population, revealed widespread malnutrition among the elderly and agreement that it could be prevented. The study found that doctors and nurses who specialize in geriatrics and administrators of hospitals, nursing homes, and home care agencies agree that nutrition plays a major role in prevention, treatment, and recovery from illness and disease.

The survey showed that malnutrition is a serious problem affecting significant numbers of the elderly population (one out of four) inside and out of health care facilities. Among hospitalized elderly patients, the rate of malnutrition was estimated to be 50 percent. The health care professionals surveyed strongly agreed that routine nutrition screening and treatment is a cost-effective way to address this crisis, and that the lack of direct reimbursement is a major obstacle to providing treatment. There is broad consensus among those who care for the elderly that nutrition screening and treatment should be part of a basic benefits package reimbursed by the government or other third-party payers.

Nutrition Screening and Treatments

Mr. Chairman, malnutrition in our society is a tragedy and costs us millions of health care dollars each year. President Clinton mentioned that older persons often must make a choice between drugs and food. From experience we can tell you that food usually loses. Pharmaceuticals are almost universally considered by the elderly as being more important to their health than nutritious food. They will purchase their drugs and reduce their food intake or at least the quality of food purchased. We must teach them that proper diet is a necessity not a luxury. Without food you die or more certainly you die sooner and your care is more expensive. We ask you to consider several approaches to addressing this problem through health care reform.

As the health care reform package is developed here in Congress, the basic benefits package should specifically include nutrition screening, nutritional counseling, a full component of meals services and nutritional supplements. The President's proposal does not specifically provide coverage for these important health care approaches, but does not exclude them either. Nutrition screening should be done when a health professional has reason to believe that the individual may be malnourished. Once an individual has been evaluated and determined to be malnourished, appropriate services and treatments should be arranged. In some cases individuals may simply need to be linked with community-based meals programs or other resources. In other cases, they may need nutrition supplements or therapies to bring their health up to a less vulnerable level.

Nutritional supplements are often prescribed by physicians to enhance the diets (speed the recuperation or improve the health status) of older persons. Home-delivered meal providers often encounter such cases. These supplements should be an allowable reimbursement in the health care system, but they do not and should not be used to replace nutritious food. They are in many cases

similar to a drug in the sense that a drug should be used to follow the particular diagnosis and enhance the treatment plan. Physicians are consistently frustrated when patients, unable to bear the cost of the prescribed nutrient supplement, either go without or reduce the amount used. In some cases Medicaid has recognized these supplements as a reimbursable expense. It is ironic that when an older person's health deteriorates from an improperly supplemented diet, hospital admission or readmission usually occurs and these services are eligible for reimbursement.

In the long run, the expenditures for these programs will seem insignificant compared to the savings in health care costs associated with unnecessary or prolonged hospital and nursing home stays, and all their related services, medications, and therapies. For example, according to the Nutrition Screening Initiative, malnourished patients compared to well-nourished patients recover 40 percent more slowly, have two to three times the number of complications, have hospital stays that are \$5,000 more expensive for medical patients and \$10,000 more expensive for surgical patients, and are 90 percent longer. In addition, the malnourished patients are more likely to be readmitted.

Mr. Chairman, we are not alone in our strong support for coverage for nutrition screening and treatments. The Nutrition Screening Initiative (NSI) which I mentioned earlier is a five-year multifaceted program to promote routine nutrition screening and better nutrition care for all Americans. NANASP is a member of the NSI Advisory Committee made up of 30 key organizations and professionals from the fields of nutrition, medicine, and aging. We have successfully developed tools to evaluate levels of malnourishment and firmly believe that appropriate screening and intervention will save millions of dollars in avoidable health care expenditures. The U.S. Conference of Mayors has also recently passed a resolution stating that any health care reform plan should provide coverage for nutrition services, including screening, assessment, counseling, and treatment.

Nutrition and Community-based Long-term Care

NANASP is extremely pleased that the President's health care proposal contains coverage for home and community-based long-term care for persons of all ages. For many years NANASP, other organizations representing older adults, and the public have been calling for long-term care coverage for all Americans. Although President Clinton's proposal is not comprehensive, it is an excellent start and, we believe, must be included in the final legislation in order to obtain the support of the older Americans that we serve and many of the groups that represent them. Long-term care is a critical issue for nearly all American families and important to both young and older voters.

Many individuals do not realize that the aging network and nutrition service programs are already playing a major role in long-term care by enabling persons to stay healthy and live in their communities. Providing more meals at congregate meal sites actually does mean buying fewer beds in nursing homes. The other major role that we play in the long-term care arena is to provide home-delivered meals to millions of elderly and disabled individuals who might otherwise be forced prematurely into an institutional setting. Home-delivered meals have become an integral part of the health care system in most communities providing necessary community-based post discharge and health maintenance to the elderly.

The Older Americans Act Nutrition Program for the Elderly should not and cannot bear the burden alone, for providing home delivered meals to those older persons requiring post hospital discharge nutrition services. Resources under the Act are woefully inadequate to meet the burgeoning need. In many cases transfer of funds from the congregate program to home-delivered services has

crippled efforts of the meal provider to provide congregate services, which are of themselves a proven preventive health service. We're feeding the ill at-home older person, with funds that could have been used to prevent or forestall that illness. Please consider reimbursement for home delivered meals that are prescribed by physicians. The fact that good nutrition and good health go hand-in-hand seems almost too obvious to mention again, but there absolutely is a critical role for nutrition in the maintenance of, and restoration to, optimal health.

Nutrition programs across the nation are ready to expand their services as part of a community-based long-term care program. To accomplish this expanded role, nutrition programs will develop a continuum of nutritional support including: 1) Access/care coordination - nutrition screening and assessment, nutrition case management, and service planning, arrangement, and follow-up; 2) Direct services - up to 3 meals per day, modified diet meals, therapeutic meals, meal supplements, nutrition education and counseling, and shopping assistance. In addition, NANASP and its members are in the best position to develop distinctive delivery models to respond to the various segments of the older population and other dependent populations. We believe it would be foolish not to utilize the existing nutrition network to provide nutrition treatments under a new long-term care program.

We also believe that the long-term care program must have a reliable funding source, clear federal standards regarding basic services to be covered, and a reasonable phase-in period.

Mr. Chairman, we know that there are hungry and malnourished individuals in our society and this should not be. Health reform provides us with yet another opportunity to address these problems. If individuals are appropriately treated, we will have improved their health and we will have saved millions of dollars in health care costs.

Mr. Chairman, we thank you again for including us in today's hearing, and look forward to working with you on reforming our health care system.

Mr. McDERMOTT. Thank you.

The Chairman has asked, several times, the panels today the question that I am going to pose to you; and that is: What system do you find of reimbursement that gives the least difficulty if you had to pick one from Medicare, Medicaid, to CHAMPUS, to whatever, private insurance companies, Blue Cross, Blue Shield, who deals with your issues in the most unobtrusive manner?

Mr. DOHERTY. Mr. Chairman, I think it is hands down that the private insurance carriers deal with reimbursement issues much more effectively and in a streamlined manner with the least amount of paperwork.

And I guess if I had to rate Medicare and Medicaid, beyond that, Medicare is certainly far greater or better than Medicaid. But Medicaid is ridiculously difficult to deal with.

Mr. McDERMOTT. Are you talking about reimbursement level, or are you talking about the actual paperwork involved?

Mr. DOHERTY. I am talking about the process of getting reimbursed. The levels vary in Medicaid from State to State obviously.

Medicare, with our industry, we are under a national fee schedule; so there is no variance from State to State. The private insurance carriers are reimbursing pretty much at the level that Medicare is, many times higher.

Mr. McDERMOTT. Mr. Wren.

Mr. WREN. Unfortunately, as basic as good nutrition is to a person's health, very few places reimburse for the cost of nutrition support. The only experience that I have with that in Ohio is a Medicaid waiver program which helps support nursing home eligible clients in their own homes.

But there are very little resources available for nutritional support.

Mr. McDERMOTT. Mr. Williams.

Mr. WILLIAMS. My perspective would be on a personal basis. Medicare was a nightmare just because of the paperwork and the reluctance at the time that I was dealing with it, which was in the early 1980s, some time ago; and it has probably changed a lot for providers to deal with.

Third-party payers, generally, are pretty good to work with and at least give you clear answers, expeditiously. And that is the biggest difference, I think, from a consumer standpoint.

Mr. McDERMOTT. OK.

Well, I thank all three of you for coming and staying until the end. I think that sometimes witnesses wonder if this makes a difference, but the staff reads this, members read it, even though there is always too much to do, it is important that we hear from people from all aspects of the health care arena. Otherwise we don't know what is going on out there.

And sometimes if you are going to avoid Murphy's law, that is the law of unintended effect, you have to know something about what is actually going on out there.

The hearing stands adjourned.

[Whereupon, at 2:56 p.m., the hearing was adjourned to reconvene at 10 a.m., Monday, November 15, 1993.]

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON PROVIDERS AND CONSUMERS

MONDAY, NOVEMBER 15, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning. Today we will continue our series of hearings on health care reform hearing from public witnesses. We will focus on a variety of issues relating to health benefits.

A number of the health reform bills would establish a standard benefit package for all Americans. Earlier this year, the subcommittee held 2 days of hearings with public witnesses to consider issues concerning benefits and services and whether or not they should be included in the package and to what extent they should be included. Today, we will examine the benefit package proposed under the President's Health Security Act.

The design of the benefit package is one of the many important points of any health reform plan and deserves careful consideration. It will affect the quality of care and, indeed, the cost of any package. As a benefit package is analyzed, and after Congress receives cost estimates by the Congressional Budget Office, it indeed will have serious effects on how we design the plan.

Over 30 witnesses are scheduled to testify today, and if Walt has the clock going, we will adhere to it pretty rigorously. I intend to keep the hearing moving. We will work right on through the day. If there are witnesses who are waiting, you will have to gauge your time, but we will work right on through the lunch period. We hope today that the specific issues will be explained to members and they will have a chance to have their questions answered.

I would like to welcome our first panel of witnesses, which includes representatives of organizations concerned with issues affecting women's health. I would like to welcome Pamela J. Maraldo—

Ms. MARALDO. That is right.

Chairman STARK [continuing]. Who is an R.N. and president of the Planned Parenthood Federation of America; Kate Michelman, who is president of the National Abortion Rights Action League;

Joan Kuriansky, chair and executive director of the Older Women's League and the chair of the Campaign for Women's Health; Ann Kolker, public policy director for health and reproductive rights at the National Women's Law Center; Donna Murasko, professor of microbiology and immunology at the Medical College of Pennsylvania; and Ann Polk, who is the cochair of the Susan G. Komen Breast Cancer Foundation.

I welcome you all. Did I miss anybody; outrageously mispronounce any names? If not, we will have you lead off and enlighten us in the order I called your name.

As with all witnesses today, your prepared testimony will appear in the record in its entirety and the Chair would ask that you proceed to summarize it or expand on it or informally enlighten us in any way you are comfortable. Dr. Maraldo, would you like to start?

Ms. MARALDO. Yes, thank you very much.

Chairman STARK. One other admonishment to the witnesses. This committee is not nearly in the forefront of technology certainly as the medical providers of the world, and our microphones only work if you practically swallow them, so for the benefit of our guests, the reporter, and the members, if you would get them up real close when you talk, it will help us all. Thank you.

**STATEMENT OF PAMELA J. MARALDO, PH.D., R.N., PRESIDENT,
PLANNED PARENTHOOD FEDERATION OF AMERICA**

Ms. MARALDO. Thank you, Mr. Chairman. It is a pleasure to be here this morning.

I am Pamela J. Maraldo, president of Planned Parenthood Federation of America, the Nation's oldest and largest reproductive health care provider.

For over 77 years, Planned Parenthood has been a model of providing affordable community-based care that emphasizes prevention—in many ways the model that health reform is trying to emulate. We have nearly 1,000 clinics serving 5 million clients nationwide—many of whom often have no other source of health care.

Mr. Chairman, I have three points to make this morning. First, that all reproductive health services should be included in the basic health care package. All the money in the world will not be enough for a universal system of health care until we begin to address the epidemic levels of unwanted births and teen pregnancies in our society.

All around us we see the legacy of unwantedness. Our cities are beehives of crime, drugs and poverty—situations that place an extraordinary burden on our health care reform system.

Health is more than the absence of disease; and the vicious spirals that stem from unwanted births and neglected children, the babies having babies spiral, the drug abuse sexually transmitted disease spiral or the parental neglect child abuse spiral place endless demands on a health care system ill-equipped to cope with them. But these are just as real health problems as heart disease and cancer.

Second, prevention must be the unequivocal emphasis of the plan. We have abundant evidence that what happens to you early in life has a profound effect on you later in life. Until we begin to emphasize prevention we will be a Nation greatly at risk.

We spend \$29 billion a year on families started by teen mothers. We have the highest rates of teen pregnancy and infant mortality in the Western World. We have a national epidemic that is killing our friends and colleagues, and we still do not have comprehensive sex education and contraceptive services integrated into our health care system.

Prevention is what reproductive health care is all about: Stemming the increase of unplanned pregnancy and sexually transmitted diseases through sex education and contraceptive services; reducing infant mortality and low birth weight through prenatal and obstetrical care; promoting early detection and treatment of reproductive cancers through Pap tests and breast exams and averting the devastation of unwanted pregnancy through family planning and safe legal abortions.

My third and final point is that abortion is an essential aspect of reproductive health care and it is a public health issue and a fact of life for American women. It must be included in the plan.

Bill Gradison, the former ranking member of the committee and current president of the Health Insurers Association of America recently put it best. He said abortion should be treated the way it is today in the plans. It is a matter that is covered under pregnancy-related services and a matter of medical judgment and that is the way it ought to be treated in the future.

In summary, Mr. Chairman, we urge that the health plan guarantee a complete range of reproductive health services for all and that special consideration be given to the needs of adolescents and underserved populations. In this regard, it is critical to keep title X and other public health service programs intact as we make the transition to become essential community providers under the new plan.

Reproductive health services save money, save lives and will go a long way toward repairing our social fabric in this health reform debate.

Thank you very much for the opportunity to be here this morning, Mr. Chairman.

Chairman STARK. Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF PAMELA J. MARALDO, PH.D., RN
PLANNED PARENTHOOD FEDERATION OF AMERICA**

I am Pamela J. Maraldo, president of the Planned Parenthood Federation of America, the oldest and largest voluntary family planning agency in the United States. I appreciate the opportunity to participate in this hearing.

We at Planned Parenthood are heartened by the momentum toward health care reform. We understand well the crisis in America's health care system because our clients are those whose needs have been all but ignored by that system.

Health is not merely the absence of disease. America's epidemic levels of unwanted childbearing and teenage pregnancies are just as much health problems as heart disease and cancer. Here are the facts:

Last week, the Department of Health and Human Services released a study finding that at least 22,000 babies were left in America's hospitals during a one-year period by parents unwilling or unable to care for them. Research has found that children born unwanted are more likely than wanted children to perform poorly in school, use alcohol and drugs, and engage in criminal behavior. America has higher rates of teenage pregnancy, abortion, and childbearing than most of the Western world. And American taxpayers spend \$25 billion a year caring for families started by teenage mothers.

All around us we see the legacy of "unwantedness" -- our cities are beehives of crime, drugs, poverty, and homelessness. If we're serious about health care reform and about prevention, we must begin with comprehensive, readily available reproductive health care.

The Southern Governors' Project on Infant Mortality Reports: Every three minutes, a girl aged 10-17 gives birth in the United States. That stark fact spells tragedy for mother, father and child, and it costs our communities enormously in both human and economic terms. Prevention is our best hope of ending this epidemic and helping our children grow up before they have children of their own.

Prevention is what reproductive health care is all about: stemming the tide of unplanned pregnancy and sexually transmitted diseases through sexuality education and contraceptive services; reducing infant mortality and low birth weight through prenatal and obstetrical care; promoting early detection and treatment of reproductive cancers through Pap tests and breast examinations; and averting the devastation of unwanted pregnancy through family planning.

For over 77 years, Planned Parenthood clinics have offered a model of preventive, community-based, cost-effective, quality services. With our nationwide network of 919 clinics, we provide an entry point for millions of patients into the health care system. Much of our appeal rests on our promise of confidentiality. Everyone -- but especially teenagers -- must be assured that their care will be confidential, or they simply will not pursue needed reproductive health services.

Given the controversy it can engender, family planning services are unique and forever in jeopardy as a public health priority. Equally jeopardized are the millions of teens and lower-income women who depend on subsidized health care. We urge that the Title X Family Planning program not be dismantled or defunded until an alternative program for ensuring accessible family planning services is firmly and securely in place.

Abortion also is an essential component of reproductive health care. Bill Gradison, the former ranking member of this subcommittee, and current President of the Health Insurance Association of America agrees. As he recently said:

[Abortion] ought to be treated the way it is today in the plans. It is a matter that is covered under pregnancy-related services and it's a matter of medical judgment -- is it medically necessary and appropriate? And that's the way it ought to be treated in the future.

Abortion, too, is an important public health issue. The American Medical Association's Council on Scientific Affairs reported in December 1992 that as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be an increase in mortality and morbidity among women in the United States.

In summary, the health benefits package must include the complete range of reproductive health services for all. They save billions of dollars in public and private-sector expenditures for health-related costs and other social services. And the vast majority of Americans support access to reproductive health care.

In addition, we urge that the health reform effort be mindful of the special needs of adolescents and disadvantaged populations. They must be guaranteed confidentiality of services, easily accessible community-based clinics, and effective counseling, education and outreach programs.

We should not underestimate our opportunity to tackle, through health care reform, problems of even greater human suffering and societal hardship.

Thank you for your consideration.



January 10, 1994

Hon. Pete Stark Chairman
Subcommittee on Health
U.S. House of Representatives
Committee on Ways & Means
Washington, D.C. 20515

Dear Mr. Chairman:

In our testimony before your subcommittee on Nov. 15, 1993, the President of PPFA, Dr. Pamela J. Maraldo, quoted a statement attributed to the president of the Health Insurance Association of America, Bill Gradison, made on the CBS TV show "Face the Nation" a few weeks earlier. The statement said, in essence, that abortion should be covered in the benefit package of any health care plan Congress approves, as it is today in most private plans.

Unfortunately, the statement was not made by Mr. Gradison but rather by former Gov. Dick Celeste of Ohio, appearing on the same show. The CBS transcript erroneously attributed the statement to Mr. Gradison.

I would appreciate your inserting this letter into the record behind our testimony to clarify things. We regret the inconvenience.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Bill Hamilton', is written over the typed name.

William W. Hamilton, Jr.
Director, Washington Office

cc: Pamela J. Maraldo, Ph.D., R.N.
Hon. Willis Gradison, HIAA

Chairman STARK. Ms. Michelman.

**STATEMENT OF KATE MICHELMAN, PRESIDENT, NATIONAL
ABORTION RIGHTS ACTION LEAGUE**

Ms. MICHELMAN. Mr. Chairman, I thank you for the opportunity to appear here today.

I want to begin by commending President and Mrs. Clinton for proposing a health care plan that addresses women's needs—a plan that would help end the shameful neglect toward women that has long characterized this Nation's health care system. How Congress shapes this plan will profoundly affect American women and their families for generations to come.

One vital way the President's plan addresses women's needs is by ensuring access to comprehensive reproductive health services. This is critical because reproductive health care is an essential component of primary care for women through most of their lives. Women's ability to make and carry out reproductive choices is essential to their health and the well-being of themselves and their families.

Through the exercise of their reproductive choices, women are taking personal responsibility for their own and their families' futures. When a woman makes a reproductive health decision to use birth control, to begin or to continue a pregnancy, to seek prenatal care, to have an abortion, or to be treated for infertility, each is a life-shaping decision that only she can make.

NARAL believes that health care reform is our Nation's chance to change course, to encourage personal responsibility, to respect a woman's right to choose, and to make abortions less necessary through prevention, contraception and family planning.

The new health care plan needs to ensure women the ability to make responsible decisions, not limit the choices they can make. If the health care plan is to fulfill its promise, it must cover the full range of reproductive health services, including abortions. Private insurance plans typically recognize that pregnancy termination is an essential component of women's reproductive health and provide coverage for the procedure. The new national health care plan cannot do any less.

Excluding abortions from the plan would be discrimination against women and especially devastating to low-income and rural women. It would exacerbate the already severe shortage of abortion providers by further isolating them, and it would recklessly and unnecessarily put women at risk.

Mr. Chairman, Americans do not believe that government should be in the business of deciding which women can have abortions and which women cannot. Abortion is a medical decision to be made in private by the woman with her doctor. Americans are looking to Congress to act responsibly to ensure the health and well-being of women and their families.

I urge you not to succumb to antichoice political pressures. I urge you to enact a plan that fosters healthier planned pregnancies, decreases the number of unintended pregnancies and makes abortions less necessary—not more dangerous, not more difficult—less necessary. Only by doing so will you truly protect women's health.

In conclusion, Mr. Chairman, a national health care reform program that based coverage for pregnancy-related medical services on political preferences and not on the medical needs and conditions of the individual pregnant woman would significantly limit women's ability to protect their health and well-being. Excluding abortion services would have the tragic effect of transforming much needed health care reform into a dangerous and discriminatory denial of women's basic health needs.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]



CELEBRATING **25** YEARS OF DEFENDING CHOICE

TESTIMONY SUBMITTED FOR THE RECORD

**KATE MICHELMAN
PRESIDENT OF THE NATIONAL ABORTION RIGHTS ACTION LEAGUE
ON NATIONAL HEALTH CARE REFORM
HOUSE WAYS AND MEANS COMMITTEE
NOVEMBER 15, 1993**

Reproductive health care is an essential component of primary care for women and must be included in the comprehensive benefits package that will be mandated under national health care reform. No medical rationale supports the exclusion of abortion from national health care reform. According to the Association of Reproductive Health Professionals: "Advances in reproductive medicine, including access to safe, legal abortion services, have produced unquestioned health benefits for women."¹ Anti-choice politics should not be permitted to jeopardize women's health by eliminating access to legitimate and essential reproductive health services. Moreover, excluding abortion services from the basic benefits package would prove unacceptable to Americans because it would take away services currently covered under most private health insurance policies.

Abortion is an Integral Part of Women's Health Care

Assuring adequate health coverage for all Americans -- the primary goal of this effort to reform the nation's health care system -- must mean assuring that every person will have genuine access to the basic medical services that he or she may be expected to require in the course of life. For most women, reproductive health care is the major form of health care that they receive during most years of their lives. Thus, for American women, comprehensive health care coverage cannot exist without guaranteeing coverage for reproductive health care.

Different women have differing reproductive health needs, and even the same woman has differing reproductive health needs at different stages of her life. A comprehensive national health care program must provide coverage for the whole woman throughout the many stages of life. For example, at different stages of her life, one woman might need routine gynecological exams, treatment of gynecological illnesses, various forms of contraception, and pregnancy-related treatment including pregnancy testing, prenatal care, and abortion. National health care cannot isolate one procedure for discriminatory treatment, but must assure coverage for the whole range of reproductive health care options.

Pregnancy is a health condition that requires medical attention based on a woman's individual needs, not political concerns. Care for pregnancy may involve medical services for pregnancy termination, or services to bring the pregnancy to term. Private insurance plans typically recognize abortion as integral to women's reproductive health and provide coverage for the procedure as part of pregnancy-related care.² Determining coverage for pregnancy-related medical services based upon anti-choice politics rather than on the medical needs and condition of the individual woman would severely harm women's health and well-being.

The vast majority of women require pregnancy-related medical services at some point in their lives. Most women become pregnant and more than eight out of ten will have at least one child. An estimated two-thirds of American women will have at least one unintended pregnancy in the course of their lives.³ In any single year, more than six million women become pregnant, and 3.4 million of these pregnancies are unintended.⁴ Legal abortion is one of the most commonly performed and safest surgical procedures. It entails half the risk of death involved in a tonsillectomy and one-hundredth the risk of death involved in an appendectomy.⁵ The American Medical Association recently concluded that "the risk of dying from pregnancy and childbirth has declined substantially over the past 50 years, but remains substantially greater than the risk of dying from a legal abortion."⁶ The risks of medical complications also are higher for childbirth than for abortion.⁷

All women must have the opportunity to make decisions about their reproductive health and to implement their choices through access to the full range of health services, including contraception, prenatal care and abortion. Providing coverage will ensure that women have the opportunity to make reproductive health care decisions and enable them to take personal responsibility for themselves and for their families. A health care reform program that encourages responsible decision-making by assuring access to reproductive health services will result in fewer unintended pregnancies, fewer abortions, and more healthy women and healthy babies.

Excluding Abortion Would Endanger Women's Health and Exacerbate the Current Shortage of Abortion Providers

National health care reform will significantly change the health care delivery system in this country and access to medical services not covered in the benefits package will be limited. The effect of exclusion would be particularly devastating for abortion services given the host of other anti-choice strategies being pursued to make abortion unavailable. Only women who could afford to purchase services outside the benefits package, and who could find a physician trained and willing to perform the procedure despite its exclusion from coverage, would have access to abortion. Some women who could not overcome these substantial obstacles would be compelled to resort to unsafe illegal abortions or forced childbearing, and others would suffer delays resulting in more risky procedures. The American Medical Association in a recent study concluded that:

If national or state funding regulations . . . deter or delay women from seeking an early termination of pregnancy . . . then more women are likely to bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that would endanger their health.⁸

Forced Pregnancy and Childbearing

Some women who are denied access to abortion will be forced to carry unwanted pregnancies to term. Forced continued pregnancy subjects women to serious physical risks and burdens that range from prolonged discomfort and pain to a substantial risk of medical complications, and even death. For healthy women, the risks increase if the pregnancy was unintended and the woman is forced to carry to term against her will.⁹ Even in cases where a pregnancy is wanted and planned, the onset or worsening of a disease or medical condition may create a need for abortion. Among the medical conditions that present increased risks to women's health during pregnancy -- sometimes to the point of threatening the woman's life -- are preeclampsia, cardiovascular disease, cancer, high blood pressure, kidney disease, immunological disorders, asthma, diabetes, and AIDS.¹⁰ For many women faced with these conditions, abortion is, at times, the only procedure that can safeguard their health.

Risky Delay

Excluding coverage would increase the health risks for women who terminate their pregnancies by imposing financial and other constraints that cause risky delays. Although a first or second trimester abortion is substantially safer than childbirth, after eight weeks the risks of death or major complications from abortion significantly increase for each week of delay.¹¹ Financial obstacles often require women to delay their abortions. Approximately half of the women who obtained abortions after 16 weeks of pregnancy were delayed by the difficulties of raising money to pay for the procedure.¹² Low-income women on average obtain their abortions two to three weeks later than middle- or upper-income women.¹³ Even women of means may be forced to delay their abortions while looking for a provider. The American Medical Association recently concluded that "as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States."¹⁴

Unsafe Abortion

Any government policy that limits access to safe and legal abortion services will threaten women's health by forcing some women to resort to unsafe alternatives. Lack of insurance coverage led an estimated 2,000 women to seek illegal abortions during the first year in which federal coverage for abortion was prohibited.¹⁵ When legal abortion became widely available in the United States as a result of *Roe v. Wade*, the number of abortion-related deaths dropped sharply and non-fatal complications of abortion diminished as well.¹⁶ Between 1972 and 1974 the total number of reported abortion deaths declined from 88 to 48, and reported deaths from illegal abortions declined from 39 to 5.¹⁷ Between 1973 and 1985 there was more than a fivefold decline in the number of deaths per 100,000 abortions.¹⁸ Women who are unable to locate trained physicians willing to provide abortion services or are unable to afford the cost of purchasing services not provided in the benefits package would be forced to turn to self-induced or unsafe, illegal abortion.

The Shortage of Abortion Providers

Excluding coverage for abortion from the comprehensive benefits package mandated under the health care reform program would also exacerbate the already severe shortage of abortion providers, further isolate physicians who perform abortions, and deter medical schools from providing training in the procedure. In 83% of counties in the United States not a single physician offers abortion services; North Dakota and South Dakota have only one abortion provider each. Anti-choice extremists across the country are using violence, threats and intimidation to pressure physicians to abandon their abortion practices. The American Medical Association concluded in a recent study that "a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions have the potential to threaten the safety of induced abortion."¹⁹ Just such a dangerous reduction in the availability of providers can be expected if the national health care package isolates and excludes abortion from the basic benefits package.

The dramatic decline in the number of abortion-related deaths after abortion became legal and available in the United States was in part due to an increase in the number of residency programs offering training in abortion procedures and training opportunities for practicing physicians.²⁰ Since 1985, however, such training opportunities have substantially decreased. The number of obstetrics-gynecology residency programs that routinely offer training in first trimester abortions declined from 23% in 1985 to 12% in 1992; the number providing training for second trimester abortions fell from 23% to 7%.²¹ Although abortion is one of the most common surgical procedures women undergo, more than one-fourth of obstetrics and gynecology

residency programs offer no abortion training.²² Anti-abortion extremists are targeting medical schools in an attempt to eliminate all abortion training.²³ Excluding abortion from the comprehensive benefits package would further stigmatize the abortion procedure and diminish abortion training opportunities in the nation's medical schools.

Conclusion

A national health care reform program that based coverage for pregnancy-related medical services on political preferences and not on the medical needs and condition of the individual pregnant woman would significantly limit women's ability to protect their health and well-being. Excluding abortion services would have the tragic effect of transforming much-needed health care reform into a dangerous and discriminatory denial of women's basic health care needs.

Endnotes

1. Amici Curiae Brief of the Association of Reproductive Health Professionals, et. al., in Support of Appellees at 12, Webster v. Reproductive Health Services, 492 U.S. 490 (1989).
2. Bertjane Levine, "A Belated Debate Over Abortion Funding?," L.A. Times, Apr. 22, 1993, E1, E3; Rochelle Sharpe, "Abortion Coverage Looks Like Most Bitter Pill For Some in Prescription for Health-Care Reform," Wall Street Journal, May 11, 1993, A20; National Women's Law Center, Reproductive Health: An Essential Part of Health Care, June 1993, 4.
3. U.S. Bureau of the Census, "Fertility of American Women: June 1988," Current Population Reports, Series P-20, No. 436, 1988: 17; Jacqueline Darroch Forrest, "Unintended Pregnancy Among American Women," Family Planning Perspectives, vol. 19, no. 2 (Mar./Apr. 1987): 77.
4. Rachel Gold, Abortion and Women's Health (Washington, DC: Alan Guttmacher Institute, 1990): 11.
5. Warren M. Hern, Abortion Practice (Philadelphia: J.B. Lippincott Co., 1984): 23-24.
6. American Medical Association, "Induced Termination of Pregnancy Before and After Roe v. Wade, Trends in the Mortality and Morbidity of Women," JAMA vol. 268, no. 22 (Dec. 1992): 3235.
7. Amici Curiae Brief of the American Medical Association, et. al., in Support of Appellees at 10, Webster v. Reproductive Health Services, 492 U.S. 490 (1989); Jane E. Hodgson, ed., Abortion and Sterilization: Medical and Social Aspects (London: Academic Press, 1981): 159.
8. American Medical Association, "Induced Termination of Pregnancy," 3238.
9. Willard Cates, Jr., "Legal Abortion: The Public Health Record," Science, vol., 215 (Mar. 26, 1982): 1587.
10. Ibid., 659, 796, 806, 813, 816-17, 836-37, 858, 859-61.
11. Nancy Binkin, et. al., "Illegal-Abortion Deaths in the United States: Why Are They Still Occurring?," Family Planning Perspectives, vol. 14, no. 3 (May/June 1982): 165.
12. Aida Torres and Jacqueline Darroch Forrest, "Why Do Women Have Abortions?," Family Planning Perspectives, vol. 20 (July/Aug. 1988): 169.
13. Stanley K. Henshaw and Lynn S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," Family Planning Perspectives, vol. 16, no. 4 (July/Aug. 1984): 170.
14. American Medical Association, "Induced Termination of Pregnancy," 3238.
15. Willard Cates, Jr., "The Hyde Amendment in Action," Journal of the American Medical Association, vol. 246, no. 10 (Sept. 1981): 1111.
16. Willard Cates, Jr., and Roger W. Rochat, "Illegal Abortions in the United States: 1972-1974," Family Planning Perspectives, vol. 8, no. 2 (Mar./Apr. 1976): 87; Michael B. Bracken, PhD, et. al., "Hospitalization for Medical-Legal and Other Abortions in the United States 1970-1977," American Journal of Public Health, vol. 72, no. 1 (Jan. 1982): 30.
17. Willard Cates, "Illegal Abortions," 87.
18. American Medical Association, "Induced Termination of Pregnancy," 3232.
19. Ibid., 3237.
20. Ibid., 3232.
21. Helene Cooper, "Medical Schools, Students Shun Abortion Study," Wall Street Journal, Mar. 12, 1993, B1.
22. Philip D. Darney, et al., "Abortion Training in U.S. Obstetrics and Gynecological Residency Programs," Family Planning Perspectives, vol. 19, no. 4 (July/Aug. 1987): 158, 161.
23. Helene Cooper, "Medical Schools," B1.

Chairman STARK. Ms. Kuriansky.

**STATEMENT OF JOAN A. KURIANSKY, CHAIR, ON BEHALF OF
THE CAMPAIGN FOR WOMEN'S HEALTH, AND EXECUTIVE
DIRECTOR, OLDER WOMEN'S LEAGUE**

Ms. KURIANSKY. Thank you, Chairman Stark, and thank you for the opportunity of testifying before your subcommittee today.

I am Joan Kuriansky, executive director of the Older Women's League and chair of the Campaign for Women's Health. The campaign is a broad coalition of over 80 national State and grassroots organizations representing more than 8 million individuals nationwide.

Since we last testified before you, the country has made a giant step forward in proposing significant reform of the health care system. Important legislation like the American Health Security Act and the proposed plan by the President challenges the country to create a health care system which ensures that Americans have universal coverage and comprehensive benefits.

For too long, medical research, health care delivery and payment systems have failed to address women's changing needs. Many of our needs are like that of men and others differ. Women's health includes treating diseases and conditions which affect women differently than men, or which are unique or more prevalent or more serious in women.

The campaign has established a model benefits package, which we include in our testimony today. Central to that package is the availability of preventive and primary care, a full range of reproductive health care and long-term care services. We applaud the President in his submission of a health plan which mandates a comprehensive benefits package and incorporates many of the benefits in our proposal.

Underlying the President's plan, and consistent with the campaign goal, is a standard of care which includes all services which are medically necessary or appropriate for the maintenance and proposals of health. Additionally, the plan makes a commitment to ensure that mandated benefits not offered by an individual plan still be available to consumers.

This plan must assure that women have easy and reasonable access to these services and where an individual plan does not provide a mandated benefit, the Federal plan must state unequivocally that the plan should make a referral to another service, provider or plan and pay for that service.

The campaign supports a system of preventive and primary care which includes periodic history and physical exams like that reflected in the President's plan. Importantly, the Health Security Act offers a wide range of services including clinical preventive services and prescription drugs.

We are particularly pleased that clinical preventive services are provided for free with no cost, or no copayments. Blood pressure screening, urinalysis, annual clinical breast exams should also be part of that annual regular exam, as should screening for osteoporosis and domestic violence and the availability of an anonymous HIV AIDS testing and counseling.

We have already heard from some of our peers in the campaign of women's health on the importance of reproductive health. The speakers before me are all members of the campaign and I only can reiterate their commitment and our commitment to a full range of reproductive health care services.

I would like to mention that women spend up to one-third of their lives postmenopausal. It is important that a reform system include access for primary physicians who are able to diagnose and counsel women about the physiological and psychological effects of menopause and long-term care. It is clearly a woman's issue.

We are very encouraged by the President's inclusion of a substantial benefit for home and community-based long-term care in the Health Security Act. We would prefer to see a mandated range of services in an acute plan and we would like to see an administrative and financial system put in place to ultimately include institutional and nursing home care in the long-term care setting.

My written testimony goes into the importance of providing a variety of providers and settings from which women can choose to get health care and, in conclusion, I want to comment on the importance that women's health advocates be included in hearings, boards and commissions and other regulatory bodies.

Health care reform offers a unique opportunity to redress some of the inequities women have faced in obtaining adequate health care for themselves and their families. The Campaign for Women's Health believes a central step in achieving equality in the establishment of comprehensive benefits is reflected in both the President's plan and the Wellstone-McDermott bill. We are committed to working with the President and the Congress to ensure a broad range of benefits is mandated in the legislation which ultimately becomes law. Thank you.

Chairman STARK. Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF JOAN A. KURIANSKY
CAMPAIGN FOR WOMEN' HEALTH**

CHAIRMAN STARK AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to testify before your subcommittee today. I am Joan Kuriansky, Executive Director of the Older Women's League (OWL) and Chair of the Campaign for Women's Health (CWH). On behalf of the Campaign, we applaud your efforts to address the issue of benefits, which are vital to women's concerns in health care reform.

The Campaign for Women's Health is a broad coalition of over eighty national, state and grassroots organizations including women's support groups, unions, and health care organizations representing more than eight million individuals nationwide. An outgrowth of a women's health task force established in 1986 to monitor and respond to national health care initiatives, the Campaign convened in 1991 to ensure that women's needs are addressed in health care reform. Providing leadership, advocacy and public education, the Campaign strives to achieve a health care system which is sensitive to the needs of all women.

Since we last testified before you, the country has made a giant step forward in proposing significant reform of the health care system. Important legislation like the American Health Security Act of which you are a co-sponsor and the proposed plan by the President challenge the country to create a health care system which ensures that Americans have universal coverage and comprehensive benefits. The two principles of access and benefits go hand in hand and are essential to promoting a system responsive to women's health needs.

As noted in our earlier testimony, the Campaign for Women's Health has established a set of principles by which we evaluate health reform proposals. Our principles are based on the recognition that women's requirement for health and well being have largely been ignored by the current health care system. Medical research, health care delivery and payment systems have failed to address women's changing needs. Women's health is like the health of men in the importance of maintaining good health, preventing disease and disability, treating illness and creating the circumstance for the optimal well being of every individual. Women's health also includes diseases and conditions which affect women differently than men or which are unique, more prevalent or more serious in women. Any reform of the current health system must include a renewed understanding of women's reproductive health. A number of severe chronic and acute disease disproportionately affect women such as lupus, arthritis and osteoporosis. Women are the fastest growing segment of the population with HIV. Women live an average of seven years longer than men and are more likely to suffer from chronic diseases, this, they are in special need of adequate long-term care services.

In addition to biological difference, social and economic factors conspire to impede women's access to quality care. Studies have shown that women are more vulnerable than men. They are less likely to get needed care than men. In fact, the recently released Commonwealth Fund study on women's health found that 10% of women did not get needed care and 35% postponed needed care in the last year. Women of color are particularly vulnerable.

Because women are more likely to be poor than men, affordability becomes a barrier to care for many women. The mean income of women is about half of that of men. And the average income of a woman over 65 is \$8,044.00. Despite the existence of Medicare, she already spends up to 30% for out of pocket health care costs. The Campaign's own study on Medicaid and women, as well as other studies, have shown that poor women do not currently receive adequate preventive health care unless they meet Medicaid standards and are pregnant, and receive prenatal care. In fact, more than one third of all women are at risk for undetected treatable health conditions.

Because of these factors, the issue of access, affordability and choice of providers are intrinsically linked to a discussion on health benefits.

The Campaign, through the work of many of its members, has established a model benefits package which we include in our testimony today. Central to our benefits package is the availability of preventive and primary care, a full range of reproductive health care and long term care.

We applaud the President in his submission of a health plan which mandates a comprehensive benefits plan and incorporates many of the benefits which are included in our proposed model benefits package. At this point, we also want to acknowledge the inclusion of a broad range of benefits in the American Health Security Act.

Underlying the President's plan and consistent with the Campaign's goals is a standard of care which includes all services which are medically necessary or appropriate for the maintenance and promotion of health. In creating such a standard the President's plan makes clear that health care is far more than merely the treatment of illness, disease, accident or disability. Additionally, the plan makes a commitment to ensure that mandated benefits, not offered by an individual plan still be available to consumers. However, if we are to finally eliminate the two-tiered system of health care where poor women do not have access to a full range of services, the health system must assure that women have access to services not available in a particular plan which is reasonable and does not pose an insurmountable burden. The federal plan must state unequivocally that where an individual plan does not provide a mandated benefit the plan should make a referral to another service provider or plan and pay for that service.

Primary and Preventive Care.

The Campaign for Women's Health supports a system of preventive and primary care which includes periodic history and physical exams. Such an exam would include blood pressure checks, urinalysis, total blood and cholesterol tests, screening age appropriate for osteoporosis, mental health, dental, vision care, speech and hearing functions. Access to affordable prescription drugs and devices should be included. Also necessary are evaluations for nutrition, drug and substance use. Evaluation for harassment and violence prevention is also necessary. Every 15 seconds a woman is beaten in her own home. Studies have shown that medical expenses are greater and physicians visits more frequent for victimized women versus non victimized women at a ratio of 2:1. Routine domestic violence screening by health professionals, recently endorsed by the A.M.A., is still uncommon but essential.

Another important component of primary and preventive care is anonymous testing and counseling for HIV. The Centers for Disease Control (CDC) estimates that by 1995, 75,000 women will have AIDS as compared to 26,000 today. Studies by the CDC have shown that persons who are tested at anonymous test sites are more likely to seek additional care. Universal, anonymous testing with pre-and post-test counselling will encourage more women to be tested and thereby may save lives.

The Health Security Act offers a wide range of services including periodic routine check-ups, clinical preventive services, and prescription drugs. In establishing a policy that clinical preventive services are to be provided for free with no co-payments, the plan begins to rectify the dilemma that many women currently face in being unable to pay for such care.

In addition to what the President's plan already includes in the routine exam blood pressure screening, urinalysis and annual clinical breast examinations should be added. The bill fails to include any screening or treatment of osteoporosis -- yet it is a major cause of death and disability in women. Osteoporosis screening and prevention should include an evaluation of risk factors counselling and if necessary medical intervention.

The plan does not specifically mention domestic violence screening as part of the plan's free preventive services. HIV/AIDS testing and counseling is limited to that available through designated community based clinics and requires a co-payment.

We applaud the President's inclusion of health education and training in the plan, however it remains an optional service with cost sharing.

Gynecological Care Including Reproductive Primary and Preventive Health Care.

Gynecological care including reproductive health services is an inseparable part of primary and preventive services for women. The full complement of these services are linked to one another and are an integral part of women's health and well being. Reproductive health services should comprise a continuum of services over the life course that precede, include, and follow the child bearing years. Regular gynecological history and periodic exams are essential primary care for women. A full range of maternity care services, including prenatal, intrapartum and postnatal care, are necessary to promote good health for both mother and child. Family planning services, evaluation and counseling for sexually transmitted diseases and menopause must also be included. Safe, affordable abortions, associated with a decline in maternal mortality, low-birth weight infants and neonatal mortality, must be offered among the full range of reproductive services available to women.

Importantly, the Health Security Act establishes a table of periodic exams for a range of gynecological needs including pap smears, pelvic exams and screening for some sexually transmitted diseases. Similarly the plan offers a schedule for mamogram screenings that would be part of clinical preventive services, available without cost sharing. We urge the President and Congress to establish a schedule consistent with the American Cancer Society and the American College of OB Gyns which can take into account evolving standards based on new research.

We will work with the President and Congress to ensure that family planning services are offered consistent with the language which we have adopted and described above. In offering both family planning and services for pregnant women, the plan goes a long way in addressing the need for women to have adequate counseling and services to avoid pregnancy and where necessary terminate it. The provision of both contraceptive drugs and devices should be clarified as a defined covered benefit.

Infertility affects 2.3 million couples in the U.S. It is important that the plan specify that infertility counseling, diagnosis, and conventional treatments for infertility are included.

Despite the fact that the majority of women spend up to one third of their lives post menopausally, there is not inclusion of counseling or treatment of menopause as a covered benefit. Some of the health difficulties associated with menopause include vaginal and urinary tract changes, things of thinning of bones and changes in mental health. A reformed system should include primary physicians who are sensitive, able to diagnose and treat physical symptoms and counsel women about alternative therapies to alleviate possible physical discomforts associated with menopause.

Prescription Drugs and Devices

Because women consume more drugs and spend more money on drugs than men the availability of prescription drugs is an important benefit offered in the Health Security Act. We applaud the inclusion of the prescription drug benefit in both the acute plan and in Medicare. However, we remain concerned about the benefits relative to its costs and co-payment requirements which are as outside the annual out of pocket maximum in the acute plan.

Long Term Care

Long term care is a woman's issue, family issue and an intergenerational issue. Women are both more likely to need long term care services and are the providers of such services. 62% of women over age 85 either reside in nursing homes or need assistance to live at home. Almost 80% of long term care is provided by unpaid caregivers, usually women family members.

We are very encouraged by the President's inclusion of a substantial benefit for home and community based long term care in the Health Security Act. We would prefer to see a mandated range of services like that in the acute plan rather than a mere listing of optional services. At the very least, the Campaign recommends an accountability structure that will assure needed services are received and avoid a provider driven system. Also the benefit is less secure than others because of the state option to undertake the program. Nursing home and institutional care, other than that which exists through the current Medicaid program is not included in the Health Security Act. Because women makeup almost three quarters of all those who need institutional care, the lack of it implicitly discriminate against woman. The Health Security Act establishes three long term care programs, yet the way in which they are integrated is somewhat unclear. The plan must clarify the process of integration.

Choice of Settings and Providers.

Lastly, the Campaign for Women's Health believes that women's health needs will be best served if health services are offered in a variety of settings and by a variety of providers. Examples of cost effective settings which would increase access to affordable care include: community health, rural health and migrant health centers; public health and family planning clinics; school-based or linked clinics; and allied health practitioners offices. Community based care means primary, preventive and long term care would be more accessible and less costly than it is today.

Women should also have the option of care from the health care provider of their choice, including the choice of women providers. Providers should include not only physicians, but nurse practitioners, clinical nurse specialist, certified nurse midwives, lay midwives, licensed clinical social workers, optometrists, podiatrists, psychologists and other allied health practitioners. The ability to select from a variety of providers for care would provide care in a more efficient, affordable and coordinated manner than is currently available. Midwives are an example of alternative providers offering accessible, appropriate and cost-effective care to women. Working in a range of settings in the community, midwives offer maternity care services with a minimum of costly interventions. In addition, studies of midwifery care demonstrate that the care is equal to that of physician care, but that some morbidity rates are lower, surgical procedures are fewer and breastfeeding rates are higher.

Summary

Accountability must be built into the process. Women's health advocates representing women of different races and sexual orientations must be included on health boards, commissions or other regulatory bodies. Such a policy should be established by law.

Health care reform offers a unique opportunity to redress many of the inequities women have faced in obtaining adequate health care for themselves and their families. The Campaign for Women's Health believes that a central step in achieving quality health care is the establishment a comprehensive benefits package like that incorporated in the Health Security Act, and in the Wellstone-McDermott bill. We are committed to working with the President and Congress to ensure that a broad range of benefits is mandated in the legislation which ultimately becomes law.

We are grateful to be given an opportunity to present this testimony today. We would like at this point to submit our Model Benefits Package for Women in Health Care Reform to the record. On behalf of the 52% of the population whose interest we represent, we thank you.

A MODEL BENEFITS PACKAGE FOR WOMEN IN HEALTH CARE REFORM

Introduction

Health care reform offers an opportunity to redefine the dimensions of health and health care. While the public has understood for some time that health care is not the provision of medical services, the system has not. Currently our health system is quick to pay expensive bills for CAT scans, while it ignores the essentials of primary care, the cost-effectiveness of preventive care and the importance of long term care.

Creating an appropriate standard under which a core benefits package is established is key to the success of the entire system. Carefully reviewing current and proposed qualifying language, the Campaign established the following standard: **All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.**

We do not recommend the application of a medically necessary standard because we believe it is inconsistent with the promotion of good health. Although the term medically necessary is not yet defined in pending legislation, many earlier proposals applied the medically necessary standard embodied in Medicare. As defined by law, Medicare covers services necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body part.

Defining a benefits package solely on the basis of medically necessary services could contradict the goal of comprehensive health care reform and in some instances be contradictory to provision of preventive services, a full range of reproductive services including abortion, and long term care.

Primary and Preventive Care

The shift towards a cost-conscious health care system which prevents illness, disease and disability invites a strong emphasis on primary and preventive care for women. The majority of primary and preventive care services are low-cost, low-tech services which can be provided by a range of health practitioners in one-stop, out-patient settings. Most primary care services do not require a physician, other than for consultation and referral. The provision of the primary and preventive care services for women listed in this summary would address the majority of common health problems seen daily by primary care providers. Equally important, these same services also screen for cardiovascular and infectious diseases, cancers, injuries and the other major causes of death and disability in women.

Periodic History and Physical Exam, Including Blood Pressure Check, Urinalysis and Cholesterol Screen. Personal health history and family history are reviewed to predict which patients are at risk for disease. Screens for common diseases such as diabetes and hypertension prolong life and are cost-effective. A full physical exam also includes an eye exam, thyroid evaluation and urinalysis. Blood pressure and weight checks as well as cholesterol screening evaluate the patient for cardiovascular disease, the leading cause of death for American women. Evaluations for nutrition, tobacco use, exercise, drug and substance use and violence, as well as mental health status, are completed. *Regular, periodic primary care visits provide the most important assessment of health status.*

Osteoporosis. Osteoporosis is a major cause of death and disability in women. It is a preventable, progressive disease which afflicts 50% of women over the age of 45 and 90% of women over 75. This bone-thinning disease results in 1.3 million fractures each year and over 50,000 deaths, costing an estimated \$7-10 billion annually. Yet, *the disease is largely preventable by alerting younger women to the importance of dietary changes, weight-bearing exercise and calcium.* In women over age 35 bone loss may be arrested with a combination of diet, exercise, calcium supplements and, in high risk women, with estrogen replacement therapy and other treatments.

Mental Health Screen. Women suffer twice the rate of clinical depression as men. However, three-quarters of American women who experience clinical symptoms of depression never receive treatment. Some forms of anxiety disorder are also more common in women. An overwhelming percentage (90%) of eating disorders occur in women. And, in general, women's experience of mental illness differs from that of men, requiring appropriate screening and treatment. Over 20% of primary health care visits are mental health related. The American Psychological Association states that parity of mental health benefits with medical/surgical benefits is cost effective. *Routine mental health screening for women would ensure improved detection of mental illness in its earliest stages.*

Domestic Violence. Every 15 seconds an American woman is beaten in her own home. Women are twice as likely to be injured by violence as to be diagnosed with cancer. Battering is the single major cause of emergency room visits by women. The health consequences of violence against women result not only in bruises, broken bones, infection and disease but, in long-term mental health problems as well. The costs can be high -- medical expenses are 2.5 times higher and physician visits twice as high for victimized women versus non-victimized women. *Emergency room protocols to identify victims have been initiated in some hospitals but, should be made available nationwide.* Police arrest programs have demonstrated that *early intervention may be effective in breaking the cycle of violence.* However, *routine domestic violence screening by health professionals -- recently endorsed by the AMA -- is still uncommon.*

Dental Check. Women are 20 times more likely than men to experience temporomandibular joint dysfunction (TMJ). Pregnant women show a significant increase in gingivitis and tooth decay. Post-menopausal women are 90% of individuals with Sjogren's syndrome, an oral cavity disorder. *Failure to treat preventable tooth decay results in more than \$16 billion in annual costs.* Dental screening would identify dental problems in women at early, preventable stages.

Vision Check. Diabetic retinopathy is a serious complication of diabetes, leading to blindness if left unchecked. African-American women have twice the risk for diabetes as white women. Other populations, including Native American, Cuban, Mexican-American and Puerto Rican women also have a high prevalence of diabetes. Women are a larger segment of the elderly, a population also at risk for vision problems. The National Eye Institute reports that *over half the cases of blindness due to diabetic retinopathy could have been prevented if detected early.*

Speech and Hearing Checks. Hearing loss is the most common health problem for older women where hearing loss is associated with aging rather than physiologic dysfunction. Older women often inaccurately view hearing loss as an uncorrectable consequence of aging. *Good preventive care includes a periodic assessment for speech-language and hearing function.* Limitations in independent living and functional status due to hearing loss can be reduced if detected early.

Prescription Drugs and Devices. Prescription drugs and devices are an essential component of some forms of diagnosis, prevention and treatment for women. They must be included as a covered benefit for women so that primary and preventive care can be effective in slowing or halting the progression to more serious conditions women may face. *Appropriately prescribed drugs and devices can improve health status and lower overall health cost.*

Laboratory Tests and Immunizations. Specific laboratory tests and immunizations are important diagnostic tools and serve to prevent illness and disease. For example, a fasting glucose test for a woman with a prior history of gestational diabetes may alert her and her provider to the onset of diabetes. Certain immunizations are known to be efficacious, such as DTP (diphtheria-tetanus-pertussis) and hepatitis B vaccine. *Infectious diseases such as polio were once widespread -- there were more than 18,000 cases in 1954 -- and have now all but disappeared because of basic and low-cost immunizations within primary care.*

HIV Counseling and Anonymous Testing. Women are the fastest growing population with HIV. An estimated 80,000 women aged 15 to 44 are currently infected. HIV seropositivity is now nearly equal among men and women in several tested populations. By 1995, the Centers for Disease Control (CDC) estimates that 75,000 women will have AIDS, compared to 26,000 today. *Universal anonymous testing with pre- and*

post-test counseling will ensure that women will choose to be tested. Anonymous testing should be made accessible to women, in public health clinics, family planning clinics and other settings where they seek primary care services. Studies by the CDC have shown that persons who are tested at anonymous test sites are more likely to seek additional care.

Primary and Preventive Reproductive Health Care

Reproductive health services are an inseparable part of primary and preventive services for women. The full complement of reproductive services are linked to one another and are an integral part of women's health and well being. Reproductive health services must be treated as a total package of services for women. Reproductive health is part of the continuum of services over the life course because women's reproductive health needs precede, include and follow the childbearing years.

Periodic Gynecological History and Exam, Including Pelvic Exam, Pap Smear and Clinical Breast Exam. The gynecological history and exam includes a survey of the woman's reproductive history, current sexual activity and contraceptive use. The pelvic exam includes a check for abnormalities of the uterus, ovaries, rectum and abdominal organs. Screening for and counseling about sexually transmitted diseases is included. The Pap smear detects cancer in early stages -- cancerous cells can be detected up to 10 years before invasive cervical cancer develops. *The survival rate of women with cervical cancer detected by Pap smear approaches 100%.* The clinical breast exam is performed to screen for breast cancer, the second most common cause of cancer in women. The exam is also an opportunity for the practitioner to teach breast self-exam (BSE) and to make a referral for mammography. *Regular, periodic gynecological history and exam is essential primary care for women.*

Mammogram. More than 180,000 women were diagnosed with breast cancer in 1992 and 46,000 women died from the disease. Reducing the mortality from breast cancer depends, in part, upon early detection. *Mammograms are a proven screening tool for detecting breast cancer in women. Research indicates that universal access to screening mammography would reduce breast cancer mortality by 30 percent.* However, many sub-populations of women including older, African-American, Hispanic and poor women do not get screening mammograms. Physicians failing to recommend mammograms for their patients and the lack of both public and private insurance coverage contribute to the underutilization of mammograms.

Maternity Care. The full range of maternity care services, including prenatal, intrapartum and postnatal care, are known to produce better outcomes for both mother and child. Women who lack access to prenatal care are twice as likely to give birth to low-birth-weight or premature babies. *An Institute of Medicine study reported that for every dollar spent on prenatal care to low income women, savings of \$3.38 in medical care for their low-birth-weight infants could be achieved.* Forty percent of women experience no complications during the prenatal or intrapartum period. However, the remaining 60% experience complications, about half being major complications. Maternal mortality and morbidity including infection, hemorrhage, toxemia and surgical interventions are reduced with appropriate and timely maternity care.

Family Planning. Family planning services reduce the incidence of unplanned pregnancies -- half of all pregnancies each year -- by increasing access to contraceptive services. Family planning also improves pregnancy outcomes for both mother and child by increasing the spacing between births. The National Commission on Infant Mortality estimates that 10 percent of all infant deaths would be prevented if all pregnancies were planned. *Every public dollar spent to provide contraceptive services saves an average of \$4.40 that would otherwise be spent providing medical care, welfare and social services to pregnant women.*

Abortion. Maternal mortality in New York State fell by 26% after abortion was legalized in the state in 1970. *The availability of safe abortion services is associated with declines in maternal mortality, low-birth-weight infants and neonatal mortality.* According to the Alan Guttmacher Institute, the availability of legal abortion was the single most important factor in the decrease in neonatal mortality between 1964 and 1977.

Infertility. Infertility affects 2.3 million couples or 1 in 12 couples in the U.S. *The National Center for Health Statistics reported that 1.3 million women had one or more visits for infertility treatment in 1988.* Diagnosis of infertility in women includes determining when and if ovulation occurs, the post-coital test, endometrial biopsy and laparoscopy. *The majority of infertile couples require conventional treatments, with fewer than 2% of couples using assisted reproductive technologies.* Infertility exacts an emotional toll on women, compounding the health consequences of this condition. The American Psychological Association has reported that infertility is a major risk factor for depression in women.

Sexually Transmitted Diseases. The major sexually transmitted diseases (STDs) include gonorrhea, syphilis, genital herpes, chlamydia, human papillomavirus and AIDS. *Many of the sexually transmitted diseases have no clear symptoms to alert women to seek treatment -- screening is vital.* Untreated STDs can lead to pelvic inflammatory disease (PID), a serious condition which can result in ectopic pregnancy and infertility. The Centers for Disease Control (CDC) report that at least 7 forms of malignancy have been associated with STDs. Untreated STDs can cause fetal and infant morbidity and death. *One study in California estimated that \$6 million in treatment costs could be saved in one year if patients in family planning clinics with asymptomatic chlamydial infections were screened.* A CDC pilot chlamydia screening program led to a 51% decrease in the chlamydia rate among family planning clients between 1988 and 1991.

Menopause. A majority of American women spend up to one-third of their lives post-menopausally. While menopause is a natural physiologic process, and not a medical condition, little is known about it. Some of the health difficulties associated with menopause include hot flashes, vaginal and urinary tract changes, thinning of bone and changes in mental health. *Health providers and educators can aid the majority of women to experience menopause without medical interventions.*

Long Term Care

Long term care integrates a continuum of home, community and institutional services. These services include medical services, health care, mental health services, personal care, nutrition services and social services. These services are delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity.

Long term care is a woman's issue and a family issue. Long term care is an intergenerational issue:

- 62% of women over age 85 either reside in nursing homes or need assistance to live at home
- 40% of all Americans who need long term care services are under age 65
- a majority of Americans have experienced a long term care crisis or expect to within five years
- almost 80% of long term care is provided by unpaid caregivers, usually women family members

Surveys show that Americans are willing to provide long term care for family members but, they lack support services to help them sustain their caregiving responsibilities. *Many long term care support services can be provided in the community and in the home, including:*

- for mental health care the older population needs to be better served by community mental health centers, private practitioners and nursing homes than currently
- nutritional services, including meals, counseling and education, can be provided in congregate settings and through home-delivered meals programs
- home care services, equipment and supplies, including home health aid, hospice benefit, mental health care, speech, physical and occupational therapy can be offered in the home
- social support services, including respite care, social worker, homemaker, help with heavy chores, caregiver support and training programs enable families to provide long term care
- community support services, including transportation, escort, adult day care, senior centers and information and referral services
- for prescription drugs and devices older Americans make up 12% of the population but, purchase 25% of all prescriptions written annually, paying 64% of their prescription drug costs out of pocket
- counseling services, including counseling for diet, exercise, injury prevention, tobacco use, drug and substance use, dental care, violence prevention, vision, speech and hearing care

Health Care Delivered in a Variety of Settings.

Although most Americans think of health settings as the doctor's office and the hospital, a wide variety of settings already exist for the delivery of health care. Community health, rural health and migrant health centers, public health and family planning clinics, school-based or -linked clinics and allied health practitioners offices are existing settings where a range of health services are provided. Health care reform offers an opportunity to increase and support the cost-effective delivery of affordable services in these many settings.

Health care reform also offers an opportunity to restructure consumer access to health services. Primary, preventive and long term health care can be delivered in convenient, community-based and affordable settings such as the workplace, schools, day care centers and in the home. In a restructured health care setting the hospital would no longer expend costly resources to provide primary or chronic care but, would provide only acute care services. Community-based care means primary, preventive and long term care would be more accessible and less costly than it is today.

An example of a community-based setting is a family health center, located near or at a public school and meeting the health needs of families, including women's health care needs. Community-centered care emphasizes family and individual health, convenient access and utilization of existing community resources such as schools or worksites.

Health Care Delivered by a Range of Providers.

With health care reform, women should have the option of care from the health care provider of their choice, including the choice of women providers. Providers should include not only physicians, but nurse practitioners, clinical nurse specialists, certified nurse midwives, lay midwives, licensed clinical social workers, optometrists, podiatrists, psychologists and other allied health practitioners.

In our current system many barriers prevent many non-physician providers from being full participants in the health care system. The major obstacle to their participation is the practitioner limits set by Medicare, Medicaid and other federal and state laws. *With a restructuring of the health care system we can enable a range of providers to provide health services in an efficient, affordable and coordinated manner.*

Midwives are an example of accessible, appropriate and cost-effective providers of primary and preventive care for women. Midwives work in a range of settings in the community -- hospitals, free-standing clinics, physicians offices, birthing centers and the home. Midwives offer maternity care services with a minimum of costly interventions. Yet, studies of midwifery care demonstrate that mortality rates are equivalent to those of physicians, certain types of morbidity are much lower, surgical procedures are fewer and breastfeeding rates are higher.

Conclusion

Health care reform is an opportunity to simultaneously provide health care to the 37 million uninsured and to create a system which offers accessible, appropriate and affordable health care for all our citizens. *It is a unique opportunity to redress many of the inequities women have faced securing health care for themselves and their families.*

This model benefits package for women demonstrates that the majority of health care for women does not demand complex technology or sophisticated medical settings -- both at a high cost. Rather, *the majority of health care for women is basic care which can be provided in low-cost settings by a range of efficient providers.*

Compiled by the staff of the Campaign for Women's Health:

Anne Kesper
Joan Kuriansky
Vanessa Mitchell
Alice Weiss

With Contributions from the following:CWH Health Care Strategy Core Group:

Stephanie Aaronson
Jo Blum
Chris deVries
Pat Ford-Roegner
Carolyn Head
Joanne Huestad
Donna Lenhoff
Ann Kolker
Cindy Pearson
Julie Scott
Diane Thompson
Claudia Wayne

Institute for Women's Policy Research
Planned Parenthood Federation of America
American Nurses Association
Service Employees International Union
American Association of University Women
Women's Legal Defense Fund
Women's Legal Defense Fund
National Women's Law Center
National Women's Health Network
National Black Women's Health Project
National Abortion Rights Action League
American Federation of State, County, and Municipal Employees

CWH Benefits Task Force:

Rachel Benson-Gold
Jo Blum
Carolyn Head
Jody Hoffman
Joanne Huestad
Tracy Johnson
Lisa Keeser
Katherine Kany
Ann Kolker
Lynne Lawrence
Cindy Pearson
Lois Schoenbrun
Julia Scott

Alan Guttmacher Institute
Planned Parenthood Federation of America
American Association of University Women
American Federation of State, County, and Municipal Employees
Women's Legal Defense Fund
Bass & Howes
Alan Guttmacher Institute
Federation of Nurses and Health Professionals
National Women's Law Center
American Fertility Society
National Women's Health Network
American Medical Women's Association
National Black Women's Health Project

Other Contributors include:

Patti Blumer
Ellen Battistelli
Alice Dan
Chris Gallagher
Jane Grimstad
Michelle Harrison
Linda Huss
Sarah Kayson
Gwendolyn Kelts
Jennifer Kneuss
Donna Kohlhepp
Judith Littlejohn
Janet Melant
Janet Platt McCarty
Judy Norsigian
Kelley Phillips
Dianne Porter
Jennifer Prouty
Rosemary Ruelke
Carol Sakala
Kathleen Stoll
Norma Swenson
Gillian Thomas
Fran Toler
Susan Wise
Joan Zero

The American Dietetic Association
Planned Parenthood Federation of America
Center for Research on Women and Gender, University of Illinois at Chicago
American Academy of Otolaryngology
Center for Health Policy, University of Wisconsin
University of Pittsburgh School of Medicine
National Eye Institute
American Heart Association
American Psychological Association
Illinois Caucus on Teen Pregnancy
Maryland Association of Innovative Health Practitioners
Older Women's League
American Speech-Language-Hearing Association
American Speech-Language-Hearing Association
Boston Women's Health Book Collective
American Psychological Association
Older Women's League
Nursing Administration, Brigham and Women's Hospital, Boston
American Academy of Ophthalmology
Women's Institute for Childbearing Policy
Center for Women Policy Studies/Women and AIDS Coalition
Boston Women's Health Book Collective
American Medical Women's Association
Midwives Alliance of North America
National Institute for Dental Research
American Pharmaceutical Association

Chairman STARK. Ms. Kolker.

**STATEMENT OF ANN KOLKER, DIRECTOR OF PUBLIC POLICY/
HEALTH AND REPRODUCTIVE RIGHTS, NATIONAL WOMEN'S
LAW CENTER**

Ms. KOLKER. Good morning, Mr. Chairman. I am Ann Kolker, director of public policy for health and reproductive rights at the National Women's Law Center, and I appreciate the opportunity to appear before you today.

As you know, we testified before the subcommittee earlier this year on the need for any health care reform effort to have a mandatory benefits package that includes a full range of reproductive health services. Today, we will focus on how such services would fare under the Clinton health security plan, noting, where appropriate, how such services would fare under other models that have been proposed.

The administration in their proposal has described a guaranteed comprehensive benefits package comparable to that offered by most Fortune 500 companies. A standard that covers benefits that are medically necessary or appropriate ensures coverage of a broad range of services. Preventive health is emphasized and the full range of reproductive health care services are covered. There are also provisions which take important steps in the coverage of long-term care, mental health, substance abuse and, of course, preventive health services.

If a plan is unable to provide all the mandated benefits within the plan, it must make arrangements to ensure the provision of all such services covered by the comprehensive benefits package. Plans which do not offer all the services in the comprehensive benefits package can be decertified; thus, the Clinton plan goes a long way toward covering the broad range of services which women need.

The single-payer models currently being discussed have, from the beginning, offered such a comprehensive benefit package. The services that would be covered under the plan introduced by Representative Cooper are still undefined because this proposal shifts the responsibility for defining the benefits to a national health board, something that we at the Law Center find unacceptable.

Since our last appearance before this committee, the Law Center has authored a report, "Reproductive Health: An Essential Part of Health Care," which contains a complete discussion of the importance of reproductive health care. We have provided you with a copy of this report and ask that it may be made a part of the record.

Today, I want to share with you the results of some important work we have done which demonstrates impressive public support for a health care system that covers a full range of reproductive health services.

This summer, the National Women's Law Center and the National Council of Negro Women worked with a polling firm to survey public opinion on whether reproductive health care services should be included in the health benefits package. Public support for such services is strong.

For example, two-thirds support coverage for abortions that are medically necessary and appropriate, the standard used in the

Clinton plan. Indeed, when considered in the broader context of pregnancy-related care, similar to the category of services for pregnant women under the Clinton plan, support for including abortions in the benefit package is even greater. A full 70 percent favor coverage of medically necessary or appropriate pregnancy-related care, including abortions.

Also strong is the belief that increasing programs to provide education and family planning is more effective in limiting abortions than excluding coverage from the benefits package. The results of this polling effort make clear that Americans want a health care system that responds to women's needs, including the reproductive needs.

In conclusion, Mr. Chairman, we look forward to working with you and other members of the committee to assure that the plan that is ultimately passed meets women's needs in a comprehensive and complete way.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF ANN KOLKER
NATIONAL WOMEN'S LAW CENTER
BEFORE THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

Mr. Chairman and members of the Subcommittee, I am Ann Kolker, Director of Public Policy/Health and Reproductive Rights at the National Women's Law Center. I appreciate the invitation to appear before you today on behalf of the National Women's Law Center. The Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including health care reform, reproductive rights, employment, dependent care, education, income support and tax reform -- with special attention given to the concerns of low-income women and children.

As you know, we testified before this Subcommittee earlier this year on the need for any health care reform effort to provide universal access, comprehensive coverage, and cost effective and affordable care. We emphasized the importance of having a mandatory benefits package that includes a full range of reproductive health services. Our testimony today focuses on how such services would fare under the Clinton Health Security plan -- the plan which is currently at the center of national debate. However, we will also refer, where appropriate, to some of the other models that have been proposed. It is essential that, regardless of the approach to health care reform Congress ultimately decides to adopt, women's health care needs be adequately addressed, and that women be assured access to a comprehensive benefit package, including a full range of reproductive health services.

I. UNIVERSAL COVERAGE

Reforming our health care system presents us with a tremendous opportunity to rectify a gross injustice in our current system: the high proportion of women and children who are currently uninsured. A critical aspect of any health care reform effort must be universal coverage. Universal coverage is especially important to women because women are particularly disadvantaged under our current health care system. For example, because of their lower earnings and concentration in service and retail jobs, which have low rates of employer-provided insurance, women and their children are disproportionately represented among the uninsured. Absence of health insurance has devastating consequences for women's overall health, denying them access to vital treatment or forcing them to miss prenatal care while pregnant. The failure of our health care delivery system to service poor and rural areas takes a serious toll on many women and their children, especially pregnant women and newborns. Even when available, care for preventive service is often not a covered service, putting routine check ups and screening tests out of reach for many women.

The Health Security plan would "ensure individual and family security through health care coverage for all Americans." We were pleased to hear the President emphasize that universal coverage is one of the "non-negotiable" elements of his plan. Of course, a single payer model would also satisfy the goal of universal coverage. Conversely, the plan introduced by Representative Cooper is woefully inadequate on this score. The Cooper proposal talks about universal access, but this does not necessarily translate into universal coverage. Americans have "universal access" to health care coverage today, if they have the economic resources to pay for it. The Cooper proposal does nothing to guarantee coverage to every American. Under the Cooper plan, employers can continue to drop workers whose health care is costly, or can decide not to cover any of their workers at all. The plan does not protect individuals who lose their employer-provided health care. Indeed, those individuals who are not covered through an employer still can decide that paying for health care is not their responsibility, can go without coverage, show up at the emergency room, and shift the cost to those with coverage.

It is essential for all Americans, and particularly for American women, that affordable universal coverage be the cornerstone of our national health care system. Low-income women have suffered disproportionately under our current system. The reform effort upon which we are embarking provides an opportunity to eliminate the two-tiered system of health care that has neglected poor women and their children for too long. Guaranteed coverage for all, regardless of economic status, must be a fundamental objective of health care reform.

II. COMPREHENSIVE BENEFITS

While universal coverage is a necessary part of any health care reform package, it is clearly not sufficient. Universal coverage means little without a comprehensive benefit package. The Administration has described a guaranteed comprehensive benefit package comparable to that offered by most "Fortune 500" companies. A standard that covers benefits that are "medically necessary or appropriate" ensures coverage of a broad range of services. Preventive health care is emphasized and the full range of reproductive health services are covered. Although not the focus of our testimony today, we were also pleased to see provisions which take important steps in the coverage of such services as long term care and mental health and substance abuse treatment. Riders which serve to exclude coverage of particular eligible individuals are prohibited. Moreover, if a plan is unable to provide all of the mandated benefits within the plan, it must then make arrangements to assure the provision of all services covered by the comprehensive benefit package. Plans which do not offer all the services in the comprehensive benefit package can be de-certified. Thus, the Clinton plan goes a long way toward covering the broad range of services essential to meet the health needs of women.

Of course, the Clinton plan is not unique in proposing such comprehensive benefits. The single payer models currently being discussed have, from the beginning, offered comprehensive benefits packages. The services that would be covered under the plan introduced by Representative Cooper are still undefined because this proposal shifts the responsibility for defining the benefits package to a national board. The benefits package is to be determined after the legislation has passed and becomes law. We cannot support a reform package without concrete assurances that women's health needs will be met.

A. Clinical Preventive Services

The Clinton plan guarantees coverage of preventive health services that run the gamut from routine check-ups for pregnant women to immunizations and screening services such as Pap smears and mammograms in accordance with a set schedule. High risk individuals, as defined by the National Health Board, will be eligible for testing at more frequent intervals -- also determined by the Board. Services are offered free when given at the scheduled intervals, but available at all times subject to applicable deductibles and co-payments if desired by a woman and her doctor.

A recent survey conducted by Louis Harris & Associates for the Commonwealth Fund, a New York philanthropy, found that more than one-third of the 2,500 women surveyed had not had important preventive health services such as Pap smears, clinical breast exams, mammograms, and pelvic exams within the past year. The number one reason given for not having received preventive services was the cost of the tests, despite the fact that the cost of preventive services is significantly less than the cost of treating a condition that is not discovered until it is in its advanced stages.

Coverage of preventive care is not only cost effective, but will also save lives -- 30% of deaths from breast cancer could be prevented with early detection and treatment; 9 in 10 deaths from cervical cancer could be prevented if more women had regular Pap smears. We commend the Clinton plan, as well as the single payer plans, both for recognizing the importance of preventive medicine, and for providing these services on a scheduled basis without deductibles or co-payments.

B. Reproductive Health Care Services

As we stressed in our previous testimony, reproductive health care is a critical component of the health care women need throughout their lifetime. Not only is it essential for a woman's own health but it confers health benefits to her children and sexual partners. Because reproductive health care is so crucial, it is often the first type of care a woman seeks, and for many the only form of primary care they receive.

Women's reproductive health care includes pregnancy, delivery and post-natal care; contraception; abortion; infertility services; and treatment for reproductive tract diseases, which are the leading contributors to conditions such as infertility and cancer.

We emphasized the enormous benefits to a woman of regular reproductive health care in our previous testimony before this Subcommittee. Since then, the National Women's Law Center has authored a report entitled "Reproductive Health: An Essential Part of Health Care" which contains a complete discussion of the importance to women of reproductive health care. We have provided each of you with a copy of this report and ask that it be made a part of the record.

Today we want to share with you the results of some important work we have done which demonstrates impressive public support for a health care system that covers a full range of reproductive services, including family planning and abortion. This summer, the National Women's Law Center and National Council of Negro Women asked Celinda Lake, of Mellman•Lazarus•Lake, to survey public opinion on whether reproductive health care services should be included in a health care benefits package. Public support for including such services is very strong. For example, two-thirds support coverage for abortions that are medically necessary or appropriate -- the standard adopted by the Clinton plan. Indeed, when considered in the broader context of pregnancy-related care -- similar to the category of services for pregnant women provided for in the Clinton plan -- support for including abortion in the benefit package is even greater. A full 70% favor coverage of medically necessary or appropriate pregnancy-related care, including abortion. Also strong is the belief that increasing programs to provide education and family planning is more effective in limiting abortions than excluding abortion coverage from the benefit package. The results of this polling effort make clear that Americans want a health care system that responds to women's needs, including their reproductive needs.

The President's Health Security bill covers family planning and services for pregnant women under one category. Family planning services include voluntary family planning services, and prescription drugs and devices. Although not specifically itemized, both the President and Hillary Rodham Clinton, as well as several other members of the Administration, have made clear that pre-natal care and abortion are included in the category of services for pregnant women. Similarly, although infertility services are not itemized, it is our understanding that they are covered in this section as well. Like the Clinton plan, the single payer models also provide coverage for reproductive health services.

The federal government has long recognized the importance of contraceptive services by providing funding for family planning services in several programs. Medicaid, the single largest source of public funding for contraceptive services, provides a favorable 90% federal-state funding match for family planning services, including all approved contraceptives. In addition, the federal government dedicates one federal program, Title X of the Public Health Service Act, solely to these services. This federal commitment is mirrored by the growing recognition among private insurers that family planning is an essential and cost-effective service. It is critical that any federally supported health care plan include coverage for family planning services.

While coverage for family planning services will go a long way toward reducing unintended pregnancies, our national health plan must nevertheless respect a woman's choice by covering abortion. Abortion is a safe and effective procedure to terminate an unwanted pregnancy, especially when performed early in pregnancy when 90% of the abortions are done. Indeed, it is far safer than childbirth. Moreover, the legalization of abortion, coupled with improvements in medical technology and the trend toward earlier terminations have made abortions even safer.

In our current system, private insurance plans already have substantial experience covering abortion. An informal survey by the National Women's Law Center confirmed that major insurance carriers including a number of Blue Cross/Blue Shields from across the country, as well as Aetna, The Principal Financial Group, and Employer's Health all report that they commonly provide coverage for abortion services. Indeed, Michael Chee, a spokesman for Blue Cross of California states, "This is not a new phenomenon. Private insurance has paid for abortion for quite a while."

A similar finding was recently reached in an informal survey conducted by the Los Angeles Times. According to this study, spokespersons for Blue Cross/Blue Shield of California, Pacificare Health Systems, Inc., and Kaiser Permanente indicated that it is the practice of their companies to cover abortion services. Thus, including abortion as a covered service would merely be a continuation of current practice. To deny comprehensive coverage for this service to the millions of women who are presently covered is simply not acceptable.

* * * * *

Mr. Chairman, in conclusion, it is vital for our nation's health that we develop a comprehensive health care system that covers all Americans and that meets the entire spectrum of women's reproductive health needs. As our polling results prove, Americans strongly support a health care system than responds to women's needs, providing coverage for the full range of reproductive services. President Clinton's Health Security plan goes a long way toward achieving these goals, but is by no means the only way to do so. Whatever shape health care reform ultimately takes, it is essential that women's health needs be fully and adequately met. Our nation's health depends on it.

Chairman STARK. Dr. Murasko.

STATEMENT OF DONNA MURASKO, PH.D., PROFESSOR AND ACTING CHAIRMAN, MICROBIOLOGY AND IMMUNOLOGY DEPARTMENT, MEDICAL COLLEGE OF PENNSYLVANIA

Ms. MURASKO. Thank you, Mr. Chairman, and members of the subcommittee. I am Dr. Donna Murasko, professor and acting chair of the Department of Microbiology and Immunology at the Medical College of Pennsylvania.

I appreciate the opportunity to discuss with you today the concerns that the Medical College of Pennsylvania observes in inequities in both research and treatment of women's health care needs in the United States and in the world.

The Medical College of Pennsylvania is not new in its interest in women's health. Founded in 1850 as a female medical college, we strove to have the education of women physicians be increased. Although the institution became coeducational in 1969 and changed its name to the Medical College of Pennsylvania in 1970, it has maintained its commitment to both the education of women physicians and to the fostering of health care needs of women.

The Medical College of Pennsylvania applauds the numerous legislative actions that have been initiated regarding women's health. However, without minimizing these efforts, we would like to emphasize that we feel this is just the beginning of an effort that must be continued. Historically, women's health needs have not received the attention, either in research or in health care delivery, that has been given to men's health issues.

In clinical trials as well as preclinical trials, women have been systematically excluded. This includes the exclusion of female animals in preclinical trials. We, therefore, have very little information on whether or not all the treatments today are equally effective in males and females.

Women have not received as aggressive treatment in many diseases, including cardiovascular disease and nutrition. Nor have they been given access to necessary preventive treatment. The health care and needs of minority women have almost totally been ignored.

With these questions and issues in mind, the Medical College of Pennsylvania has begun to develop a center for programs in women's health to address these issues. We see this as a continuum of not only health care delivery, but the education of health care providers to address these concerns and to do them effectively as well as the research necessary to provide the care that we have today and to provide the information to the future to do this more effectively.

At the Medical College of Pennsylvania, we have a comprehensive health care center. We deal with the needs of minority as well as middle class women. We have developed an integrated medical school curriculum to incorporate women's health, not as an aside but as an integral part of the medical education process. This is funded by a fund from the improvement of postsecondary education from the U.S. Department of Education.

We are developing programs to continue this not only for medical students but into the residency level, so that residents in internal

medicine will understand the needs of women and deal with their social and emotional aspects effectively and efficiently.

We feel that research must be continued not only in clinical research but in the basic causes of various diseases that are either predominant in women or may have unique features in women. And also in health care delivery systems, because women are consumers that are different than men and need to have different health care delivery systems.

In addition, although we can rely on the current administration in academic medicine, which is predominantly male, to implement the programs that we hope will be established in the near future, we would feel more comfortable with an increasing number of women in administrative positions in academic medicine, and to this end the Medical College of Pennsylvania is establishing a leadership institute for women in academic medicine.

We hope that Congress will use this opportunity to implement and include in their package information and funding for health care delivery as well as research in terms of basic and clinical research in health care delivery and for helping women achieve levels that will help maintain and continue the emphasis that is currently focused on women's health.

We hope to work with you in any way possible to help this be a success and help for all women. Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF DONNA MURASKO, PH.D.
MEDICAL COLLEGE OF PENNSYLVANIA

before the

HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

November 15, 1993

Mr. Chairman and members of the Subcommittee, I am Dr. Donna Murasko, Professor and Acting Chairman of the Microbiology and Immunology Department at the Medical College of Pennsylvania, the first and longest surviving medical school devoted to the education of female physicians. I appreciate the opportunity to testify before you today. I would like to take this opportunity to tell the Subcommittee about the Medical College of Pennsylvania's concerns with the inequities that currently exist in research and treatment in health care for women and the efforts the College has undertaken to address these issues.

The Medical College of Pennsylvania was founded in 1850 as the Female Medical College of Pennsylvania. In 1969, the institution became coeducational and in 1970 changed its name to the Medical College of Pennsylvania. Yet, despite changes in the institution's name and student body, the Medical College of Pennsylvania remains deeply committed to its roots as a pioneer in educating women in the medical profession and fostering critically needed education in those areas effecting women's health. This historic commitment continues to be reflected in the high percentages of women admitted to the school of medicine, and in the proportion of women holding senior level academic and administrative ranks, including professors, department chairs and deans. Today, the College has twelve residency programs featuring numerous programs and studies, either underway or in development, which significantly affect women's health care research and treatment.

Needless to say, the Medical College of Pennsylvania applauds the numerous legislative initiatives that have been introduced to enhance the focus and services of women's health care. However, without minimizing their importance we believe these are only just beginning steps toward creating a system that is truly fair and effective for women. Today, I would like to share with you those inequities we have identified in the current health care system which we believe can be reduced or eliminated as the health care delivery system experiences major reform.

Historically, women's health needs have never received the quality research and treatment provided to men. Women have been systematically excluded from medical research studies. This exclusion of females has even encompassed clinical studies in animals, based on the assumption that hormonal fluctuations was a confounding factor in the experimental design. Women have received less aggressive treatment for diseases such as those affecting the cardiovascular system and nutrition, and have been provided minimal access to important preventive services. Moreover, almost no research has been completed to understand the health needs of minority women. Clearly, there is a tremendous need to recognize and rectify the gender bias which exists in medicine and medical research today. I believe President Clinton's health care reform package is a perfect starting point.

While the areas of concern to women's health care are vast, today I would like to recognize as an example of inequity one disease that affects tens of thousands of women each year; breast cancer. Breast cancer is the leading killer of women between the ages 35-53. In 1993, it is estimated that 182,000 women will be diagnosed with breast cancer. Of these women, 46,000 will die.

Mammography is the best known method of early detection of this tragic disease. The number of women who have mammograms is increasing among women of all ages. However, among black women, the screening rates have remained unchanged.

At the Medical College of Pennsylvania we are working diligently to increase those numbers. Currently, we operate a Mobil Mammography Program. Introduced to the Philadelphia area in 1992, this community service seeks to identify breast cancer when it is still in its earliest, and most curable stages. The program seeks to break down the sociological barriers to mammography, including the cost, fear, and inconvenience of the procedure. The Medical College of Pennsylvania's mobil mammography offers screening to women over 35 years of age at no out-of-pocket cost. In its first year, the mobil coach has screened over 2,700 women, of which 43% were uninsured. 13% revealed abnormal findings, 14 cases disclosed an immediate diagnosis of breast cancer.

Beyond prevention, detection, and treatment, there is a requirement for increased breast cancer research which must include investigations into the suspected risk factors and causes of breast cancer such as dietary fat, obesity, environmental contaminants, and genetic factors. Clearly, there is a need to develop improved methods of early detection and prevention. We also need to determine the short and long-term benefits and risks of breast cancer among women taking oral contraception or undergoing post-menopausal hormone replacement, for example. These studies must not be limited to associations among various parameters and incidence of breast cancer. In order to most effectively diagnosis and treat breast cancer, or any disease, the biological mechanisms responsible for development and progression of disease must be defined. This can only be done through continued support of basic research.

Efforts to address ovarian, cervical, and uterine cancers also are of critical importance. Unlike breast cancer and cervical cancers, there is no early detection method for ovarian cancer. In 1992 alone, 21,000 new cases of ovarian cancer were diagnosed and 13,000 will die this year. Tragically, these statistics point to the demand for increased research.

These are only a few examples of critical needs affecting women. Obviously many more exist. In recognition of the need to address the comprehensive health care requirements of women, the Medical College of Pennsylvania is in the process of developing an Interdisciplinary Center for Programs in Women's Health. To date, the College has raised over \$1.5 million toward the establishment of the first chair in women's health in the United States to lead the efforts of the Center. The Center will encompass many women's health care and education programs, providing strategic leadership through the advancement of women's health initiatives, basic as well as clinical research and medical education.

Currently there are ten major individual research initiatives underway at Medical College of Pennsylvania that focus on women's health, spanning a wide range of clinical and basic science. Examples include a research project focusing on the effect of cocaine abuse by mothers and their children; the long-term effects of estrogen replacement in breast cancer patients, and an investigation of the interaction of marital tension and stress in women. An additional twelve women's health-related research proposals are pending with state and federal funding agencies.

Another program we are very proud of is Medical College of Pennsylvania's Women's Health Curriculum. The Medical College is the first medical school in the United States to integrate women's health education into its curriculum. The U.S. Department of Education has awarded Medical College of Pennsylvania a grant from the Fund for the Improvement of Post-Secondary Education for its implementation. The Curriculum will help to compensate the historic imbalance in medical education which has taught students the principals of health care based almost solely on male physiology.

In particular, women's health is being integrated into the teaching of first and second-year medical students at Medical College of Pennsylvania. Students will learn about medical conditions in which there are gender differences in symptoms, risk factors and treatments. The curriculum will also have a strong orientation toward community medicine, prevention, and health promotion.

Currently, women are considerably underrepresented in the senior ranks of academic medicine. Only 10% of full professors are women; only 4% of the department chairman in academic medicine are women; and there are only three women deans of the 126 medical schools in the country. We are very proud of the fact at the Medical College of Pennsylvania, 25% of the department chairs are women, and 40% of the associate deans are women. The College believes one of the reasons women continue to face challenges in gaining appropriate recognition for women's health care is because of the lack of women in leadership positions in medicine, and at academic medical centers throughout this nation.

At the Medical College of Pennsylvania, we have developed the Leadership Institute for Women in Academic Medicine. A planning grant from the Jessie Ball duPont Foundation is supporting the development of a leadership institute for women in academic medicine. The objective of the program is to increase the number of women surviving in senior leadership positions in academic medical centers throughout the country. The program will increase participants' knowledge and skills, broaden their perspective for dealing with the challenges of academic medicine, and provide a supportive network for women seeking leadership positions.

Another important program at the Medical College of Pennsylvania is the Center for Women's Health. Founded in the late 1970's as the Center for the mature Woman, the center re-located to new facilities in 1992. The center has a commitment to provide integrated health services for women with a consistent emphasis on health education and health promotion. The Center is a collaborative interdisciplinary practice which provides on site ancillary and diagnostic services. Along with a comprehensive primary care program, currently the Center offers a collection of clinical services for women that are organized into programs targeted to specific needs or concerns of women:

- **The Healthy Women Program** - provides a comprehensive approach to health care in a post reproductive age woman.
- **The Light Steps Program** - is a weight management program designed by the American dietary Council.
- **The PMS Program** - provides comprehensive evaluation and treatment to assist women in overcoming the symptoms that disrupt their lives during the menstrual cycle.
- **The Breast Health Program** - provides evaluation and treatment for women at risk for developing breast cancer, women with breast cancer, and women with breast implants.
- **Nutrition Counseling** - provides women with guidance regarding appropriate diet and the effect of nutrition on health.

As you can see, the Medical College of Pennsylvania remains committed to the implementation of a comprehensive women's health care program. The current national health care debate in which we engage today provides our nation's leaders with a critical and necessary opportunity to address the serious issues and challenges involved in this effort. It is essential that during this process Congress recognizes and includes funding not only for provision of adequate health care services for women, but also for basic research regarding diseases unique to women (eg. Breast Cancer) and diseases which may have features unique to women (eg. Cardiovascular disease) and for research on effective health care delivery systems for women. We at the Medical College of Pennsylvania hope you will not hesitate to call upon our experience in providing leadership in women's health care research and medical education, and will consider us as a resource in this critical debate.

Mr. Chairman, thank you again for the opportunity to testify.

Chairman STARK. Ms. Polk.

**STATEMENT OF ANN POLK, COCHAIR, SUSAN G. KOMEN
BREAST CANCER FOUNDATION, INC.**

Ms. POLK. Mr. Chairman and members of the Subcommittee on Health, I am Ann Polk, and I appreciate the opportunity to testify today as a representative of the Susan G. Komen Breast Cancer Foundation.

I am a nurse practitioner and cochair of the 1993 Baltimore Race For The Cure, 1 of 35 national 5K races sponsored by the Komen Foundation. Chairman Stark, you and Mr. Cardin should be particularly proud to know that your two cities have run very successful Race For The Cure events.

The mission of the Susan Komen Foundation is to eradicate breast cancer as a life-threatening disease. It is a national network of volunteers in currently 46 cities, 29 States and the District of Columbia. Having raised over \$20 million since its inception in 1982, it is one of the largest private foundations funding breast cancer research, education, screening and treatment efforts.

The Komen Foundation priorities for health care reform are several, as in our written statement. I will be focusing on the mammography screening reform.

Mammography screening, in combination with the clinical breast exam, is currently the most reliable tool for detection of breast cancer in its earliest and most treatable stages. As a breast cancer survivor, who at age 43, I had a nonpalpable breast cancer detected by a mammogram, I am a living testament to the vital importance of mammography screening.

While the Komen Foundation endorses the strong preventive services component in the President's plan, we are very concerned that it precludes access to routine mammograms until a woman reaches the age of 50. As the subcommittee reviews the coverage for preventive health care services, I and the Komen Foundation urge the Ways and Means committee to ensure that routine mammography screening is included, according to the currently recommended NCI guidelines, by reporting out health care legislation which includes mammography screening for women 40 to 49 years of age.

This is imperative until further studies examine the efficacy of screening this age group. No definitive study is currently available, and the new draft Federal policies on mammography screening present unconvincing rationale and insufficient justification based on often flawed and out-of-date data to change the current guidelines.

Early detection saves money and lives. With early detection, 30 percent of breast cancer deaths could be prevented and substantial treatment costs saved. The CDC states that breast cancer, in its earliest stages, can be treated for \$14,000 versus \$84,000 or more for advanced cases.

The Federal Government must not undermine efforts in progress made in encouraging women to get preventive measures, such as mammography screening, by now discouraging these same measures for a previously targeted group of women, especially without

conclusive data to support these changes. I refer you to our written copy for our other priorities in view of the time.

In conclusion, I understand that Congress faces difficult decisions in trying to reform our health care system and make it function within severe budget restraints. Please consider, then, that money invested in the near term to promote practices, such as screening mammography, will save money and lives long-term. Last year, 46,000 women died from breast cancer and in the next decade over one-half million will die.

My closing thought for you today is this: You do not, unfortunately, have the power to prevent breast cancer, but for the women in my age group of 40 to 49, you can give them a chance to have breast cancer my way, the best way, with the earliest possible detection, with a cure rate of close to 100 percent, by including screening mammography according to the current NCI guidelines. Without those guidelines, I may not have been sitting here before you today to testify for my generation and that of my and your daughters.

Thank you. And I do need to add that I am not the chairman of the National Foundation, Cochair, but of the local Baltimore chapter. Just wanted to correct that.

Chairman STARK. OK. But they might as well make you chairman of the national foundation. You are doing a good job and that is fine.

Thank you.

[The prepared statement and attachment follow:]

*Testimony
Ann Polk
on behalf of
The Susan G. Komen Breast Cancer Foundation*

Mr. Chairman and distinguished members of the Subcommittee on Health, I am Ann Polk, a breast cancer survivor and Nurse Practitioner from Baltimore. I am testifying today as a representative of the Susan G. Komen Breast Cancer Foundation, and appreciate this opportunity to present testimony as you consider the many challenges of national health care reform. As the Subcommittee reviews the coverage of preventive health care services in the comprehensive benefits package proposed in President Clinton's health care reform legislation, we urge you to ensure that routine mammography screening is included according to the guidelines currently recommended by the National Cancer Institute. On behalf of the The Komen Foundation, I am privileged to share its priorities for health care reform and to educate the Subcommittee about Komen's efforts to promote breast cancer awareness and find a cure for this devastating disease.

Komen and Its Mission

The mission of the Susan G. Komen Breast Cancer Foundation is to eradicate breast cancer as a life threatening disease by advancing research, education, screening and treatment. Nancy Brinker founded the Foundation in 1982 in memory of her sister, Susan G. Komen, who died of breast cancer at age 36. Since then, the Komen Foundation has grown into a thriving, vertically-integrated, volunteer-driven organization that works actively at the national, state and local levels to eradicate breast cancer as a life-threatening disease. The Komen Foundation is a national network of volunteers working through local chapters and RACE FOR THE CURE events, next year in at least 46 cities, representing 29 states and the District of Columbia. With over \$19 million raised since its inception, the Komen Foundation is one of the largest private foundations funding breast cancer research, education, screening and treatment efforts. At the conclusion of this statement is a summary of highlights of the Komen Foundation's efforts at the national, state and local levels.

Health Care Reform Priorities

• **Access to Care**

Komen commends the Clinton Administration's leadership in tackling the myriad complex and challenging issues presented by health care system reform. In particular, we support guaranteed access to health care for every American and inclusion of a comprehensive minimum benefit package. In the future, women facing breast cancer will be able to take comfort in knowing they will enjoy access to needed hospital, outpatient, laboratory and diagnostic services, prescription drugs and biologicals, and the services of physicians and other health professionals, as well as new supports for home health care.

• **Coverage of Routine Mammography Screening**

Mammography screening, in combination with a clinical breast examination, is currently the most reliable tool for detection of breast cancer in its earliest and most treatable stages. Therefore, screening and clinical breast exams must be accessible and available to all individuals according to current National Cancer Institute recommended guidelines.

While the Komen Foundation endorses the strong preventive services component in the President's plan, we are very concerned that the present proposal precludes access to routine mammograms until a woman reaches age 50. I think it is imperative that health care reform includes mammography coverage for women 40 to 49 years of age until further studies examine the efficacy of screening this age group. No definitive study is currently available, although we understand that Britain has a significant study underway.

If women under 50 have access to routine mammograms only in situations indicating need for diagnostic mammograms because of known risk factors or symptoms, the "reform" is potentially an enormous step backwards for the health status of American women in the 40-49 age category. Adequate screening must be available to women early enough to detect cancer when it is treatable. The new draft federal policies on mammography (released October 1, 1993) present an unconvincing rationale and insufficient justification to change the current NCI screening guidelines. Komen's view is that health care decisions should be based strictly on clinical data without undue consideration to health economics.

Changing the NCI screening guidelines now will result in greater confusion about the appropriate frequency for mammography screening. This makes no sense in the midst of a growing breast cancer epidemic. Private and public sector efforts alike over the past decade have targeted screening and early detection efforts particularly at women age 40 and older. Sacrificing the small strides forward -- in the absence of solid scientific evidence -- is shortsighted, at best!

Komen's recent experience exemplifies the need for consistent, scientifically sound federal mammography guidelines. The Komen Foundation has received reports from around the country that women are canceling appointments for mammograms because they no longer feel annual mammograms are necessary in light of news of the changing guidelines. The federal government must not continue to send conflicting signals to women about the need for mammography screening.

We know that early detection saves lives and money. With education, early detection and follow-up, 30 percent of breast cancer deaths could be prevented and substantial treatment costs saved. According to the Centers for Disease Control and Prevention, breast cancer found in its earliest stages can be treated for \$14,000 versus \$84,000 or more for advanced cases.

The Komen Foundation recommends that before federal policies on mammography are revised, adequate studies must be undertaken and completed. Until adequate scientific evidence is obtained, the current NCI and American Cancer Society (ACS) recommendation that women from 40-49 should receive mammograms every one to two years, should be retained. Any health plan passed by Congress should include this coverage in the standard schedule for clinical prevention services.

- **Coverage of Experimental Drugs and Treatments**

The Komen Foundation supports the inclusion of coverage for patient costs associated with clinical trials in the comprehensive benefits package proposed by President Clinton. In addition, when such treatments are appropriately prescribed by a physician, coverage must extend to all costs associated with FDA approved anti-cancer drugs, biologicals, and new investigational therapies, for their approved indications, for indications listed in the compendia, and for indications approved by peer review literature.

- **Research**

The federal government must continue to strengthen its investment in breast cancer research. We strongly support high priority research on the development of better indicators of early signs of the disease, including blood, urine and other tests to detect early genetic markers of breast cancer.

Both basic and clinical cancer research must receive funding from consistent and reliable sources at appropriate levels. The Komen Foundation believes that highest priority must be placed on funding for research into the causes and methods of prevention, early detection, and treatment of breast cancer. In addition, programs must be fostered to provide incentives, mentoring and encouragement to young scientists to work in the area of breast cancer research to cultivate and support innovative research ideas.

- **Insurance Reforms**

We applaud President Clinton for including fundamental insurance market reforms in the Administration's health care reform legislation. We support reforms which ensure that all individuals have the opportunity to purchase affordable comprehensive health insurance, which includes coverage for screening, diagnosis, treatment and follow-up for breast cancer. In particular we hope that any health reform package which is enacted by Congress eliminates

preexisting condition exclusions and guarantees enrollment, renewability and portability of health care coverage.

Conclusion

The Komen Foundation fully recognizes the difficult decisions that the Congress faces in trying to reform our health care system and make it function within the severe budget constraints that exist. Such constraints make critical the need to invest wisely the scarce dollars we do have.

From our vantage point, we have seen tremendous benefits resulting from effective, widespread education and early detection efforts. Remember, money invested near-term to promote breast health practices, such as breast self-examination, and screening mammography, will save money and lives long-term. Last year witnessed the loss of 46,000 women's lives to breast cancer alone. The financial impact of their treatment, lost wages, loss to their families of care givers, and loss to our economy of trained, productive and valuable citizens cannot be easily dismissed.

When we budget, we always seem to have the funds for the items we put first. Surely the opportunity to save significant numbers of lives, reduce the ultimate cost in dollars as well as pain and suffering, and build the infrastructure for health care for the future must be at, or near, the top of our list.

Thank you for your time and attention, and for considering the lives of millions of women and their loved ones. We invite you to join us -- early and always -- in the RACE FOR THE CURE for breast cancer.

The Susan G. Komen Foundation

In addition to supporting a balanced program of breast cancer research and promoting the importance of screening for detection of the disease, the Komen Foundation concentrates on programs to promote awareness and education of breast self-examination, detection and treatment options. Central to our program is a commitment to meet the needs of the underserved, minorities, and those least able to access health care. Through a variety of community-based efforts, the Komen Foundation works to eliminate financial, institutional, and cultural barriers to screening and treatment services. The Foundation's particular strength is its ability to create coalitions of health care facilities and providers, private/public partnerships, and volunteer-staffed model programs to provide education and awareness activities that improve access to care for breast health for all women. The most prominent of Komen's education and awareness activities include:

♦ **RACE FOR THE CURE®**

Key to the Komen Foundation's phenomenal growth in recent years is its highly successful RACE FOR THE CURE® series of 5K/1 mile race walks throughout the United States. Since the first RACE in Dallas in 1983, the series ballooned to RACES in 35 cities across the country with 125,000 participants in 1993, and we expect to run at least 46 RACES in 1994.

From each RACE, 25% of the proceeds fund national research grants, and 75% of the money remains in the RACE city for various local projects. Generally the projects involve screening, establishment of breast health centers, bilingual outreach, hospital programs such as "patient navigators" to help underserved women through the diagnosis and treatment process, and other efforts to bridge the gap between detection and treatment of breast cancer.

♦ **National Helpline**

The Komen Foundation's national helpline (1-800-I'M AWARE) uses trained volunteers to assist callers with breast health and breast cancer concerns by providing information on health and disease issues, local and regional resources, and available and affordable services.

♦ **Leadership Summits on Breast Cancer**

Since 1989 the Komen Foundation and the National Cancer Institute (NCI) have co-sponsored Leadership Summits on Breast Cancer nationwide. These Summits promote public/private partnership and encourage community-based and regional programs for awareness, screening, and treatment of breast cancer.

♦ **Biennial Symposium on Minorities and Cancer**

Earlier this year, the Komen Foundation co-sponsored The Fourth Biennial Symposium on Minorities, the Medically Underserved and Cancer, held in April in Houston, Texas. The Symposium focused on health care access, including lack of insurance, language barriers, location of health facilities and issues of employability when diagnosed with a catastrophic illness.

♦ **National Government Relations Program**

Among our efforts at the national level, the Komen Foundation works cooperatively with other cancer groups to secure substantial increases in federal funds for breast cancer research and screening. We also have played major roles in the enactment of the Mammography Quality Standards Act of 1992 and in the funding of its implementation for 1993 and beyond.

Chairman STARK. The administration, as I understand it, will attempt to preserve the status quo with respect to private insurance coverage of all reproductive procedures and all abortions.

Is there any of the panel that object to that?

Ms. MICHELMAN. No.

Ms. KOLKER. To the contrary.

Chairman STARK. Let the record show that they do not.

The benefits package specifies a schedule of coverage for certain prevention benefits and I think it has been modified for mammography. Do any of you want to comment briefly on what you think is far too minimal in the description package? You can each state it very quickly, because I don't think that package is finalized. Dr. Maraldo, do you want to just go down the line?

Ms. MARALDO. Yes, originally, as we understand it, the plan had mammographies only for women over 50. We would like to see them annually for everybody beginning in the early reproductive years.

Ms. MICHELMAN. I agree with Dr. Maraldo.

Chairman STARK. Ms. Kuriansky.

Ms. KURIANSKY. It is our understanding that mammograms will be included as free preventive clinical services when, in addition to the schedule, when there is a particular risk.

We agree with the Komen Foundation, that we have to have a standard that is flexible to take in consideration evolving medical and scientific research and that we should rely on standards like those adopted by the American Cancer Institute.

Chairman STARK. I would like to direct a question to the physicians on the panel. How early should you establish the baseline or does that vary from woman to woman? Is there an age?

Ms. POLK. Yes, I could speak to that. Only really in the case of a family history would it vary much below 40; that the recommendation is clearly to start at the age of 40.

Chairman STARK. So certainly even if it is not annual there ought to be a baseline benefit at some point?

Ms. POLK. It should start at 40 and our belief based on the data available thus far, based on the fact these have been the recommended guidelines, it is to start at 40.

There are some scientists who, because cancers tends to be more aggressive in that decade of life, that perhaps 40 to 49 should be even every year and 50 should be every 2 years, but it really should start at 40 and with at least every 1 to 2 years in that decade. There is really no conclusive data at this point to change the guidelines as NCI is suggesting to do.

Chairman STARK. OK.

Ms. KOLKER. I think one of the real dilemmas is the absence of research-based information. And I presume my colleagues would support us in suggesting that one real priority is to develop a much sounder basis of research so that there is really more knowledge upon which the guidelines can be formed.

Ms. POLK. Right. Most of the research has been targeted at curative measures, and then lately at finding causes, but if we do not focus now on when to start this early prevention, then we are not going to change the incidence and the mortality of this disease. It must be picked up before it is palpable, as was in my case, to really

ensure a cure and to really pick up. They will not all be picked up this way. There are some that will still be missed, but overall this is definitely the recommendation.

Ms. MURASKO. I would agree we should maintain the recommendation, but I think the most recent comments really emphasize how we need to continue research in the clinical delivery of these screening procedures, that we have to see that they are the most effective and to support additional research to make these more effective or come up with different screening techniques that may be more cost effective and more sensitive to developing cancers.

Ms. POLK. And one final comment is that the Komen Foundation has a hotline for women about breast cancer, and they have been receiving calls that because this is already in the press as possibly being changed to age 50, many women are cancelling their mammograms already.

There is much confusion. There is a lack of credibility now with the medical community and perhaps the political community, I don't know, but we are perhaps going to see a fall-off of women of all ages getting mammograms because they are going to say, well, they don't know what they are doing, and I think that would be very unfortunate.

In the last few years, screening has definitely made a difference in the discovery of early cancers, and to fudge around with what we have standard now, until we have further data, I think would really, really set back the progress that we have made.

Chairman STARK. Thank you, Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Ms. Kolker, you said in your opening remarks that you did not favor the concept of benefit decisionmaking that is in the Managed Competition Act of 1993, which I assume argues for a statutory decisionmaking process. In other words, Congress specifying the benefits, writing them into law and then periodically reviewing them, adding and subtracting; is that correct?

Ms. KOLKER. That seems like the soundest approach to us. Yes, that enables not only women, but everybody, to know what benefits they will be getting.

Mr. GRANDY. Well, that may be true, but is it not also true that if you allow this body to basically be the sole determinant of the benefit package, you are going to subject this committee and others and members outside the health jurisdictions to tremendous political pressures? And I would point out exhibit A might be this hearing list for today.

You have, among others who are testifying here, the American Sleep Disorders Association, the Council for Responsible Nutrition, American Heart Association, naturally, National Hemophilia Foundation, Sudden Infant Death Syndrome Alliance, Amputee Coalition of America, all of which I am sure will make compelling cases for being in the benefit package, as they have in the past.

The problem that will happen, I am afraid, is if we do not at least depoliticize this process to at least an arm's length kind of mechanism that is at least attempted in the bill that Mr. Cooper and I have advanced, is that you will basically be making decisions based on the political clout of these various groups.

One of the reasons that we created what we now call a Health Standards Commission was because we wanted at least an aloof body to make the recommendations and then Congress to vote on this up or down.

Now, as it relates to this panel, and I want to go back to something that Ms. Michelman said in her testimony, where she asked us not to succumb to antichoice political pressures, it may very well be based on what has happened already with the President's attempt to overturn the Hyde amendment and his failure in doing so, that a benefit package might be determined by Congress which would go up to perhaps allowing abortions up to but not beyond the limit of the Hyde amendment jurisdiction right now—rape, incest, life of the mother—but go no further, and that would be the statutory decision. Would you then support a health care package?

Ms. MICHELMAN. I would like to speak to that.

Mr. GRANDY. Sure.

Ms. MICHELMAN. If I might, Congressman, the Hyde amendment is a very, it is an embarrassing policy for this Nation to embrace. It is discrimination against women and particularly discrimination against poor women. It is a bad policy. It inserts government, the Federal Government, into the health care plans of women who depend on the government for their health care, inserts them into their plan, gives them the power to take out from their plan, one, Reproductive Health Service, and to determine which women can have abortions and which women cannot.

It also, the Hyde amendment literally establishes a two-tiered health care system in our Nation, one for the poor and one for those of us of means. President Clinton, in his address to the Nation on national health care reform said that one of his major goals and principles is to eliminate a biased or two-tiered health care system. He wants universal care for all of us and is attempting to eliminate things like the Hyde amendment.

The fact is that for women who now have private health insurance, many of us, in fact I would argue, the majority of us have basic health reproductive health including abortions covered. And in order for the Congress to ensure that we do not lose something that we already have, we must be able to maybe take that coverage, and for poor women, they have to have for them restored the option of abortions in order to have the medical decision that is necessary for their health and well-being.

But I don't think that the Hyde amendment, which is a very different kind of policy from national health care reform, which is intended deliberately to end the discrimination against certain members of our society, are the same at all and I don't think it would mean that we would have a Hyde amendment. I think that the health care reform allows us the opportunity to end that kind of discrimination, and I would think Congress would welcome that opportunity, not shy away from it, to end the discrimination.

Mr. GRANDY. But supposing they don't? I mean really, we do not have to rejoin this debate. You have already succeeded in protecting abortion rights under the law to a limited degree, whether or not you will succeed in protecting the right to public subsidy is another matter entirely. And I can sit here and say, well, in my view, and it is my view, that abortions discriminates the health c

women against the health of children and to pit children's rights against women's rights is not sound public policy, but I want to get back to the political decision that we are on obligated to make which is why I asked Ms. Kolker her question first.

If you put this square into the political maelstrom known as Congress, then your deals are going to get cut. That is exactly what is going to happen and I am concerned that unless we at least create some kind of depoliticized process for making these decisions, you are going to have a lot of skirmishes over these kinds of benefits which will perhaps slow down the process, perhaps completely derail it.

Ms. MICHELMAN. But the way to depoliticize it, it seems to me, is put abortion back where it belongs, which is a medical decision to be handled by the woman with her doctor. That, to me, is depoliticizing it.

We agree with you, by the way, Congressman, that the issue has been far too long a political issue, far too long a divisive issue. We need to spend our time making abortions less necessary. Put abortions and pregnancy termination back into the hands of the medical decisionmakers, which are women and with their doctors.

Mr. GRANDY. But Ms. Michelman, wait a minute. If there were on this panel a representative from the National Right to Life Organization, she would write your sentence, I urge you not to succumb to pro-choice political pressures or antiabortion political pressures. So let's admit there is still deep feeling on both sides.

Ms. MICHELMAN. There is. There is.

Mr. GRANDY. I am looking for a way, and I am pro-life and you are pro-choice, to create a benefit that helps women's preventive health care up to, but perhaps not including as far as you want to go with reproductive services and allowing public subsidies for abortions on demand.

The only reason I am asking these questions is I want to know if you did not get everything you want, would you find yourself constrained not to support the package?

Ms. MICHELMAN. First of all, there is no such thing as abortions on demand. I would like to be sure to correct the record here. It sounds as if, when you say that, that women are waking up in the morning and saying, oh, gosh, I will go have an abortion. There is no such thing. It is a medical decision, Congressman, that is a very serious one made by conscientious and responsible women who want to be successful parents. And it is a—it cannot be trivialized by being called abortion on demand.

Mr. GRANDY. I didn't trivialize it, Ms. Michelman, but my point is—

Ms. MICHELMAN. I know what your point is.

Mr. GRANDY. My point is, there are other abortions besides rape, incest and the life of the mother, and you know that.

Ms. MICHELMAN. But they are all very serious decisions.

But I would also like to speak to the issue of people who do not want their tax dollars going for something they consider to be, as you do, objectionable.

Congressman, there are so many people in this Nation, I can think of Quakers, for instance, who hold deeply, deep moral and religious views about weapons production and the conduct of war.

Deeply held views. And they resent, very strongly resent their tax dollars going to pay for weapons production. There are other groups who do not believe in blood transfusions, who resent their tax dollars paying for blood transfusions.

Mr. GRANDY. Or public taxes for the arts.

Ms. MICHELMAN. The issue is that we do not have in our Nation the right to exercise our tax dollar exemptions that way.

I do believe, and I think we would all agree on the panel, that conscience clause is a good one. It does allow doctors and health providers and religious institutions the right to conscientiously object from performing abortions. We think that is right. We believe religious freedom is important.

But what remains here is that women's reproductive health decisions cannot be teased apart as if there are different women having abortions, different women having prenatal care, different women using contraceptive services. We are all a woman. We are all the same woman, if you will. And your idea of trying to depoliticize this, I agree, I wish we could, but I think the best way to do that is to return the abortion decision to the privacy of a woman with her doctor, and not for the government to decide which women can have abortions and which women cannot.

It is not the role of government to do that, and I think by leaving it in the health care plans—and I might add that also the dollars are going to be used to enroll a woman in her health alliance, not to pay for a particular service. It is to enroll her in the alliance. You are not going to—the services are going to be determined by medical people, and so I don't think you can say which dollar is going to go for which service. It is all going to be part of a plan. Some of us will pay private dollars. So I don't know, I have spoken enough, I think.

Mr. GRANDY. OK, I will grant a cease-fire here. Let me just say that if there was someone on the panel to refute that, I would much rather have that debated among you, the participants in the discussion, rather than me.

But you know, because you have been through this battle many, many times, that there will be people who will say the conscience clause in health care is a distinction without a difference.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I don't think I will get into that issue. There is another issue that I ponder when I think about the way people are talking about reform.

The idea of a managed care is that, obviously, you have a physician who is, what is called the gatekeeper, through whom you get all your health care. You have to go to that person before you get referred to a specialist. And it seems to me that those of you who are interested in women's health would be very concerned about whether or not that person would be reluctant to make a referral to a specialist, to a gynecologist, for instance, and whether women would be, in one way or another, prevented from getting that care without going through some process that would delay. If not at least delay, delay or deny, depending on the situation.

It seems to me any financial incentive in an HMO, in a managed care situation, that makes it better for the gatekeeper not to make

referrals would, in the long term, deny women the best health care they could get. I wonder the response—I see several of you grabbing the microphone, so I think several of you might have an idea about this. I would like to hear your comments on it. Anyplace you want to start.

Ms. MURASKO. I would like to say that with the advent of initiatives like the women's health initiative, the founding of women's health care centers, the absolute basis of these centers is that this is primary health care for women. They are interdisciplinary centers that include gynecologists as primary care physicians.

This concept of primary care for women being the same primary care that a man would get at an internist should be included in this package. It is not that gynecology services are separate from this; it is an integral part of the primary care package. And if in the HMO concept managed care, regional centers, or primary care groups are set up to have this as part of the package, a women's health care package, one would not have to question whether or not this would be delayed because of a referral or the adverse financial effects on the primary care physician. This is primary care.

Ms. MARALDO. Congressman, there are two different points here. One is that the proliferation of specializations has resulted in an inadequate system of primary care prevention. Most of the \$100 to \$200 billion we spend on unnecessary surgeries in this country are in women's reproductive health. I think that the intent of the plan to put an emphasis on prevention and primary care is a good one.

Most women enter the health care system, for reproductive health reasons. So in fact I agree with the former witness that we don't differentiate between primary care and reproductive health care.

We want to make sure community-based family planning clinics continue as primary entry points and gatekeepers in the system. Women should not have to go through an HMO or another provider to get to us. Because women know us, they depend on us, and there is no reason to circumvent that or reinvent the wheel.

If your basic point is that reproductive health care is primary care and should be acknowledged in the plan as such, we would agree with that.

Ms. KOLKER. I would like to bring this discussion back to the Clinton plan, because one of the principal changes that was made between the draft plan and the document that was released was a required point of service option for HMOs. It seems to me that this will clearly benefit women who, for example, want to go into an HMO but who want to keep their OB/GYN or another specialist. The recognition on the part of the administration that a woman might have a loyalty to or experience with a service provider outside of the network of HMOs is very important for women's reproductive health care and for other needs.

Mr. McDERMOTT. How do you understand the point-of-service option actually working for the average woman?

Ms. KOLKER. That is a very good question. We have had some conversations with the administration about whether or not this has to be elected at the outset, whether you can decide during the course of the year that you want to invoke a point-of-service option. I think there are still some unanswered questions.

Mr. McDERMOTT. So your view was that you would sign up in an HMO, HMO A, and you would at that point either elect to include Doctor Y as your gynecologist, your point-of-service person, or at some point later in the year you could pick up that person?

Ms. KOLKER. We have spoken with members of the President's health care team about this question and we have not yet gotten an answer on exactly how it would work.

Ms. KURIANSKY. I think you raise an important issue, because if you look at a particular family, you may very well have a family who requires specialization from a variety of health care professionals that are not necessarily in one plan. And we are working very hard and we hope to continue to work with you all in trying to figure out a system where individual women within a family can make decisions that best reflect what their families need and not be consigned to one plan with one set of health care providers and still be able to afford it.

Mr. McDERMOTT. I think you stole my second question, which is the whole issue of the average family that has gynecologists for the woman, the pediatrician for the kids and the internist for the father, and they don't happen to all be in plan A. Which one do you choose, plan A, plan B or plan C, depending on which one you think you will spend the most money on, or that I think is a real dilemma of the managed care option, for people who have already established patterns.

If you don't have an already established pattern and you go into an HMO, you may be able to find the kind of person that you want to deal with; but if you have established patterns, as many people do in this country, it seems to me it is very difficult question to answer, is how you get people reconnected or continue the connection with people they are used to dealing with.

Ms. KOLKER. Very vexing. That is a description of our family.

Mr. McDERMOTT. Thank you, Mr. Chairman.

This is an issue on which we are going to have some more discussions and I hope you continue to be active in trade discussions. Because unless your point is pushed, it will get lost. The American health care situation today is not what you suggest, Dr. Murasko. We are moving in that direction, but we are not getting there very fast. And unless it is pushed, it will get written into law in the old way.

Chairman STARK. It is my understanding—I would share this with Mr. Grandy if he were here—but the Jackson Hole managed competition plan, leaving abortion aside, would include, quote, "only those benefits that have been shown on the basis of outcomes experience to be of value in promoting the public health and well-being."

I can see us into years of litigation if we ever get the outcomes research, which is 5 years away, and I am not sure that that is a better way than just going through a series of hearings and having us decide. But some day it may be helpful in helping us all decide what kind of benefits we think we want or it may be helpful in determining to what extent mammography is included in the basic benefit package. None of us would deny that outcomes research would be very useful. But I am not sure it is at the state yet where we can develop the benefit package.

Ms. POLK. And as we indicated with this NCI guidelines, there is no, at this point, very justifiable research reasons to change the guidelines. And I think the damage that will be done by doing that will really set back any progress we have made.

Chairman STARK. I want to thank the panel very much for their contribution today.

Our second panel will include of Dr. Irwin Redlener, who is the president of the Children's Health Fund; Dr. Stephen Saunders, who is president of the Association of Maternal and Child Health Programs; Thomas Moran, who is the president of the Sudden Infant Death Syndrome Alliance; Tom Stoddard, who is a member of the board of directors of the American Foundation for AIDS Research; and Michael Isbell, who is the director of the AIDS Project, the Lambda Legal Defense and Education Fund, Inc.

Once you are all comfortably arrayed at the table, we will let Dr. Redlener lead off.

You may proceed, Dr. Redlener.

STATEMENT OF IRWIN REDLENER, M.D., PRESIDENT, THE CHILDREN'S HEALTH FUND, NEW YORK, N.Y., AND DIRECTOR, DIVISION OF COMMUNITY PEDIATRICS AT MONTEFIORE MEDICAL CENTER

Dr. REDLENER. Thank you. Thank you, members of the committee.

I am Irwin Redlener, a pediatrician, director of community pediatrics at the Montefiore Medical Center in New York and president of the Children's Health Fund, also based in New York City.

We, as way of background, operate the Nation's largest health care program for homeless children as well as programs for indigent and underserved kids in Newark, Dallas, South Florida, South Central Los Angeles, rural Mississippi, rural West Virginia and here in the Anacostia region of the District of Columbia. Our particular health care model includes the use of fully equipped mobile pediatric offices on wheels, and is based on the precept that every child is deserving of a medical home; or, in other words, a source of stable, continuous, and comprehensive health care.

The fact that many children in America do not have such a medical home and are rather relegated to episodic expensive acute care in overcrowded emergency rooms is a national problem with grave consequences. Not the least of such concerns really a symptom of lack of access to a medical home is our Nation's appalling inability to immunize children as evidenced by the fact that less than 50 percent—in some cases, far less than 50 percent—of urban 2-year-olds are properly immunized. Most of these children who are not immunized are among what I would consider to be among the 15 million—I repeat, 15 million—American children who are in essence medically homeless.

All of these children are in fact, though, entitled to and should receive access to appropriate and comprehensive sources of health care. And this is why the details of the President's plan around benefits for children, around appropriate preventive care and periodic visits, around supportive and enabling services for special needs and disadvantaged children are so essential to make sure

that we have not just health coverage, but real access to appropriate health care for all children.

While the plan is good that the President has proposed, is it not excessive in our view and needs to be understood and kept intact as it winds its way through the congressional process. To put it another way, the President's plan offers a true medical home for all children with a range of proposed benefits which are light years ahead of where most children, many children are today.

And it is in this context and because we are so intimately involved with the health care of the country's most disadvantaged and most disenfranchised children, that I would conclude with four recommendations. First, I think there needs to be a line in the sand protecting the children's benefits as outlined in the President's health security proposal.

Second, guidance for the development of a proposed health alliances and health plans must be improved actually to recognize and accommodate the needs of all children by making sure that parents who are poor or who live in underserved communities are genuinely represented within the governance of the alliances.

Third, we strongly support the Health Security Act provisions which particularly target health care resources toward underserved children by establishing new loan programs and investments for expansion of community and migrant health centers and the national service corps, and we also support plans related to that which provide new funding to assist doctors and hospitals in rural and inner-city communities who want to form their own networks to compete with more traditional health plans.

And fourth and finally, we think that the proposed public health service funding designed to support so-called enabling services for families and children, like outreach and case management and transportation and translation services, must be absolutely guaranteed and not subject to annual economic or political vagaries.

In sum, we at the Children's Health Fund and my colleagues who are deeply involved in the provision of health care to very underserved children really see the Clinton plan as a tour de force which will provide a new vision of access to care for all Americans.

And I say this with deep respect for many of the members of this committee, and also say this having spent most of my career as an active, card-carrying, single-payer, Canadian-style reform activist. But for now and for here and for the children that we deal with, that solution is not what I would consider ideal. And I am here to tell you that I am actively and enthusiastically supporting the plan the President has proposed.

[The prepared statement follows:]

**TESTIMONY OF IRWIN REDLENER, M.D.
CHILDREN'S HEALTH FUND**

Thank you, Mr. Chairman and members of the Committee for inviting me to present testimony on President Clinton's Health Security Plan. I want to begin by thanking Chairman Stark for his unwavering support and leadership over the years for universal access to comprehensive pediatric health care coverage.

I am Dr. Irwin Redlener, Director of the Division of Community Pediatrics at the Montefiore Medical Center in New York City. My Division runs the New York Children's Health Project, the nation's largest health care program for homeless children. Since the project began in 1987, we have seen more than 50,000 health encounters with medically underserved children who are homeless or otherwise severely economically disadvantaged.

I am also President of the Children's Health Fund which, in addition to supporting the work of the New York Project, has successfully organized programs in Newark, South Florida, rural West Virginia, rural Mississippi, Dallas, South Central Los Angeles and the District of Columbia.

Our model includes the use of fully-equipped, mobile, pediatric offices affiliated with Community Health Centers and teaching hospitals and is based on the precept that every child is deserving of a medical "home" - or a source of stable, continuous and comprehensive medical care.

The fact that many children in America do not have such a **medical home** and are, rather, relegated to episodic, expensive acute care in overcrowded emergency rooms is a national problem with grave consequences. Not the least of these problems, really a symptom of lack of access to a medical home, is our nation's appalling inability to immunize children.

I know that you are aware of the fact that in many of our large urban areas, less than 50% of two year olds are up to date on their vaccination schedule. **Nearly all of these children are what I would consider to be MEDICALLY HOMELESS.**

How many medically homeless children are there?

I believe there are at least 15 million such kids.

This number may, in fact, be far too low. Here's why:

- Actually, some 9 million children are not covered by health insurance and millions more are inadequately covered under meager family health plans. Many of these children do not have a regular source of pediatric care and therefore fall into the category of medically homeless.
- Another 10 million children live in the federally designated Health Personnel Shortage

Areas (HPSAs). This group includes homeless children, children of migrant laborers, children living in isolated rural poverty and those in disadvantaged inner city neighborhoods.

Because there is unknown overlap between the children who have only fiscal barriers to care - the uninsured - and those who could not gain access to care even with an insurance card I offer this very low estimate of 15 million who are currently medically homeless.

These are children who, in any other civilized country on earth would be entitled to and receive access to an appropriate and comprehensive source of health care. This is why the details of the President's plan, around benefits for children, around appropriate preventive care and periodic visits, around supportive and enabling services for special needs and disadvantaged children are so essential to making sure we have not just health care, but real access to appropriate health care for all children.

We deal with the frustrations and tragedies of medically homeless kids every day. They are the ones who are behind in their vaccinations; they are the ones who are referred for behavior problems or learning disabilities when what they really have are unrecognized, untreated ear infections which led to hearing loss and inability to function in school. They are the ones who may go to the hospital when acute asthma literally threatens their lives, but do not have a doctor, a medical home, to control the chronic wheezing which inhibits homework or normal physical capacity.

The President's Health Security Plan holds out the promise that all children will have access to not just any health care, but the right kind of health care. The benefits in the President's plan include comprehensive and appropriately focused preventive services such as well-baby care, routine immunizations and routine dental and vision care, hospitalization and acute care of all types--and more.

Yet, the President's plan should be considered a bare minimum as far as children's health benefits are concerned. We, along with the American Academy of Pediatrics, will be fighting for additional components we feel are important and beneficial to the health of America's children, including more periodic visits, more screening and more extended support of children with special needs.

But I cannot emphasize too strongly that the President's plan offers a true medical home for all children with a range of proposed benefits which are light years ahead of where many children are now. And it is in this context, and because we are so intimately involved with the health care of the country's most disadvantaged and disenfranchised children, that I will conclude with the following four recommendations:

1. There must be a "line in the sand" **protecting the children's benefits as outlined in the President's Health Security proposal**. We do not consider this to be a package put up as an opening move to be bargained away in negotiations with any special interests. We hope you will at least hold the line for the benefits proposed in the plan and, in fact, support even further enhancements of children's services.
2. **Guidance for the development of proposed Health Alliances and Health Plans must be improved to recognize and accommodate the needs of all children** by making sure that parents who are poor or who live in underserved communities are genuinely represented within the governance of the Alliances.
3. We strongly support the Health Security Act provisions which **particularly target health care resources towards underserved children by establishing new loan programs and investments for expansion of community and migrant health centers and the National Health Services Corps**. We also support plans to provide new funding to assist doctors and hospitals in rural and inner-city communities who want to form their own networks to compete with more traditional health plans.
4. **Proposed Public Health Service funding designed to support so-called "enabling services" for families and children - like outreach, case management, transportation and translation- must be guaranteed and not subject to annual economic or political vagaries.**

In sum, our medical teams of the Children's Health Fund and the Montefiore Medical Center-Albert Einstein College of Medicine, see the Clinton plan as a tour-de-force which will provide a new vision of access to care for all Americans. We very much urge all of you to vigorously support the President's plan.

And for children, especially those who have not been getting appropriate care, the Health Security Act may be the best sign of hope their parents--and we--have ever known. As you consider this most important piece of legislation since the Civil Rights Act, please keep in mind that when the health of young children is compromised, the capacity to learn, the potential for optimal development and the chances for attaining a productive future are seriously jeopardized. The future of the nation clearly depends upon providing all children an equal opportunity to grow up healthy and educated. Let's make the most of this important opportunity.

Thank You.

Mr. McDERMOTT [presiding]. Dr. Saunders.

**STATEMENT OF STEPHEN E. SAUNDERS, M.D., M.P.H.,
PRESIDENT, ASSOCIATION OF MATERNAL AND CHILD
HEALTH PROGRAMS, AND CHIEF, DIVISION OF FAMILY
HEALTH, ILLINOIS DEPARTMENT OF PUBLIC HEALTH**

Dr. SAUNDERS. Good morning. I am Dr. Saunders, chief of the Division of Family Health, Illinois Department of Public Health, and the president of the Association of Maternal and Child Health Programs, AMCHP, for short.

AMCHP is a national nonprofit organization representing State public health programs assuring the needs of women in their reproductive years, children, youth and families. The mission of State public health programs funded under title V of the Social Security Act and AMCHP is to assure the health of all of the MCH population, including children with special health care needs.

Consistent with this mission, AMCHP developed and published a framework for analyzing health care reform which describes the essential components of personal health services coverage and systems infrastructure required to meet the needs and improve the health of the MCH population. The framework is used as the basis for our testimony today on the benefits component of the President's proposal and is being submitted for your consideration.

AMCHP applauds the emphasis in the President's plan on preventive care, the inclusion of dental services for children and the incorporation of a wrap-around package of services for poverty-level children, the development of community-based, long-term care services, authorization for enabling or support services for underserved populations, and the authorization of school health services. However, there are aspects of the comprehensive benefits package that need to be strengthened.

Medicaid currently pays for wrap-around or enhanced services for pregnant women, which do not appear to be covered in the President's plan, and we feel those should be included. While preventive health care visits for infants, children and adolescents and women are covered, the periodicity schedules do not conform with the guidelines currently established by the American Academy of Pediatrics or the American College of OB/GYN. And I should also point out that the American Academy of Pediatrics has recently been working on a new periodicity schedule called Bright Futures, which also recommends more visits than are currently in the President's plan.

The inclusion of such clinical preventive services will result in cost savings. Limitations on rehabilitation service and home health care coupled with limited eligibility for community-based, long-term care, no hearing aid services for children, will leave many children health care needs without access to specialty, therapeutic and community-family support services they require. The benefits of substance abuse treatment services should be tailored to meet the needs of pregnant women.

Finally, it is our understanding that the Health Security Act does not include financing for many of the important services listed under Title III, the public health initiatives, as was mentioned by the prior panelist. These public health population-based services

must be adequately financed to further improve the health status of our country.

AMCHP commends the administration for addressing so many of the elements the MCH population requires. We note, however, that the legislation does not support mechanisms to assure that various service elements are integrated and coordinated with key education and social services. We recommend that Congress consider such a comprehensive approach to program planning, which will reflect the priority our Nation places on the health and well-being of children and their families.

AMCHP and the Title V directors are willing to provide assistance and offer our expertise in developing mechanisms to assure comprehensive coordinated maternal and child health services.

We thank you for this opportunity to discuss the President's plan and welcome any questions.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF STEPHEN E. SAUNDERS, M.D.
ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS**

Good morning. I am Dr. Stephen Saunders, Chief of the Division of Family Health, Illinois Department of Public Health, and President of the Association of Maternal and Child Health Programs (AMCHP). AMCHP is a national nonprofit organization representing state public health programs addressing the needs of women in their reproductive years, children, youth, and families. On behalf of AMCHP, I am pleased to provide our views on the personal health services benefits included in the President's health care reform proposal.

The mission of state public health programs funded by Title V of the Social Security Act (the Maternal and Child Health Services Block Grant) and AMCHP is to assure the health of all mothers, children, adolescents, and their families, including children with special health care needs due to chronic or disabling conditions. Consistent with this mission, AMCHP developed and published a framework for analyzing health care reform which describes the essential components of personal health services coverage and systems infrastructure required to meet the needs and improve the health of the MCH population. The framework was used as the basis for our testimony today on the benefits component of the President's proposal and is being submitted for your consideration.

AMCHP analyzed the September 7, 1993 draft of President Clinton's plan and is currently reviewing the legislative language released in late October. Our criteria for personal health services coverage specify that there be payment for a comprehensive, continuous, and coordinated array of MCH preventive, primary, specialty, and long term care and support services. These services should be provided, as appropriate, in offices, clinics, schools, homes, and other alternate settings.

AMCHP applauds the emphasis in the President's plan on preventive care, the inclusion of dental services for children, and the incorporation of the "wrap around" package of services for poverty level children with special health care needs. Other elements of the benefit package which we favor include the development of community based long term services, which is critical for children with special health care needs; authorization for "enabling" or support services for underserved populations; and authorization for school health services.

Based on our preliminary analysis, we believe that the comprehensive benefit package in the Health Security Act would meet the needs of the majority of women, children, and youth in the United States. However, we would like to take this opportunity to point out aspects of the comprehensive benefit package that need to be strengthened.

Medicaid currently pays for "wrap around" or enhanced services for pregnant women, which do not appear to be covered in the President's plan. While preventive health care visits for infants, children, adolescents, and women are covered, the periodicity schedules do not conform with guidelines set by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. If preventive services are to achieve anticipated savings and improved health outcomes, they must be provided at the appropriate intervals. Limitations on rehabilitation services and home health care, coupled with limited eligibility for community based long term care, will leave many children with special health care needs without access to specialty, therapeutic and community family support services they require. The plan's mental health benefits should reflect the same specificity with regard to children's needs as do the other health services; benefits for substance abuse treatment services should be tailored to meet the needs of pregnant women. It is our understanding that the Health Security Act does not include financing for many of the important services listed under Title III, the Public Health Initiatives.

The comprehensive benefit package, long term care, school health, support services,

and the "wrap-around" program for children in poverty are some of the components of the President's plan that will provide benefits and services needed by women, infants, children, adolescents, and their families. AMCHP commends the Administration for addressing so many of the elements women, children, youth, and their families require. We note, however, that the legislation does not suggest mechanisms to assure that various service elements are integrated and coordinated with key education and social services. We recommend that Congress consider a comprehensive approach to program planning, as called for by the National Commission on Children and others, to reflect the priority our nation places on the health and well-being of our children and families. AMCHP and the Title V Directors are willing to provide assistance and offer our expertise in developing mechanisms to assure comprehensive, coordinated MCH services.

We thank you for the opportunity to discuss the President's plan and welcome questions.

Chairman STARK [presiding]. Thank you.

Are you next, Mr. Moran?

Mr. MORAN. That is right.

Chairman STARK. Go ahead.

STATEMENT OF THOMAS L. MORAN, PRESIDENT, SUDDEN INFANT DEATH SYNDROME ALLIANCE

Mr. MORAN. Thank you, Mr. Chairman, members of the committee.

My name is Tom Moran. I am president of the Sudden Infant Death Syndrome Alliance. I am here today representing a nationwide movement comprised of thousands of American parents whose common bond is that when they went in to check on their sleeping baby, they found that infant lifeless, claimed by sudden infant death syndrome.

In the last two decades alone, nearly 150,000 families have lost babies to Sudden Infant Death Syndrome. The incidence of SIDS is one in about 500 live births, and unfortunately is not a rare medical problem.

The SIDS Alliance and its over 50 affiliates throughout the country enthusiastically support health care reform and are grateful to President Clinton and Congress for tackling these complex issues.

The common experience of SIDS parents and their intense interest in matters affecting the health and well-being of all children might provide a valuable perspective to you in considering the broad policy questions and the details of health care reform. These perspectives include the following three points.

First, universal coverage is a must. Currently the availability of support services to SIDS families is an accident of geography and social status. As you can well imagine, the effect of losing a baby to SIDS puts enormous personal stress on the family unit. Parents need access to short-term counseling and support services.

Also, health care legislation should recognize the value of peer support and self-help types of mechanisms, parents helping each other. These services are cost efficient, humane and effective. As a nation, we do not hesitate to assist and counsel victims of natural disasters. We need to assist the survivors of this annual tidal wave of infant deaths attributed to Sudden Infant Death Syndrome as well.

Second, the emphasis on prevention and wellness is extremely wise. Many of the panelists this morning will comment on that. We simply add our voice to the necessity for good prenatal, postnatal care, and other medical interventions early in life which will assist in having a positive outcome for infants.

There is considerable interest today in the SIDS community that through a combination of preventive measures, smoking cessation both prenatally and postnatally, pre- and postnatal visits, infant sleep position, we might in fact have, using a combination of these interventions, the opportunity to significantly reduce the incidence of Sudden Infant Death Syndrome. However, the bottom line to this is that we don't know for sure.

Finally, this leads to the final point. Finally, and most importantly, national health care reform must promote basic biomedical research. We know precious little about the normal development

of a newborn, and therefore have very little idea about early detection and prevention of a great number of childhood illnesses, including Sudden Infant Death Syndrome.

It is ironic that 18 months ago the American Academy of Pediatrics came out with a recommendation that babies ought to go to sleep on their side or back, based almost exclusively on studies done abroad. Very few studies are done in the United States concerning SIDS. We need to correct this tendency for research of this type to be conducted overseas. We need to improve the research occurring in the United States.

In summary, over 4 million U.S. families will have a baby this year. They all share a common fear, that perhaps their baby may not reach its first birthday. Let's take some of the fear out of this parenting by emphasizing the health promotion and health research aspects through the national health care reform.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF THOMAS L. MORAN
PRESIDENT
SUDDEN INFANT DEATH SYNDROME ALLIANCE**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Sudden Infant Death Syndrome Alliance regarding the Administration's proposal to reform the nation's health care system.

The SIDS Alliance is an organization comprised of thousands of individuals and families around the country that have been devastated by the sudden unexplained loss of an otherwise healthy baby.

Sudden Infant Death Syndrome is a frightening disorder that knows no economic boundaries; it can strike an infant from any country, culture, or socio-economic status. In the typical, but horrible SIDS case, an apparently healthy infant is put to bed for the night or for a nap without any indication that something is wrong. Sometime later, the infant is found lifeless. The infant's prior medical history, a complete postmortem examination, and a thorough investigation of the death scene provides no explanation for the cause of death. SIDS leaves in its wake grieving families and frustrated health care professionals.

Mr. Chairman, each year 7,000 infants die as a result of SIDS -- one baby each and every hour of each and every day -- including holidays. SIDS is the number one killer of babies two weeks to one year old, and is a major factor contributing to the high rate of infant mortality in the United States.

SIDS & The Health Security Act

Families affected by Sudden Infant Death Syndrome vigorously applaud the Administration's initiative in health care reform. Never before has such a comprehensive review of our nation's system been done. The simple recognition that our health care system does not work for many people in this nation is a significant one. That the President has placed health care reform high on the list of national priorities is commendable.

Maternal & Child Health & SIDS

Even though very little is known about the cause or causes of SIDS, the Health Reform proposal's emphasis on guaranteed access and improved prenatal and well baby care bodes well for improved attention to infants during their first year of life. Additionally, it is known that babies born prematurely, below normal weight, and whose mothers smoke during pregnancy are at greater risk of SIDS. While there are no known standard set of predisposing factors leading to a SIDS episode, perhaps the greater attention to the health and well being of each and every infant could lead to a greater understanding of those factors that precede the unexplained death of an infant. More attention on infant health and infant mortality may provide some answers to why apparently healthy babies die of Sudden Infant Death Syndrome.

Prevention & SIDS

The foremost agonizing thought on the mind of each SIDS parent is "What could I have done to prevent this from happening to my baby?" For too long, the nation's system of health care has focused on episodic sickness, rather than preventing illness -- or even death. The SIDS Alliance has reviewed the prevention initiatives in the President's plan and believes that in many respects, the proposal represents some attention to prevention screening activities and research. However, we do not believe the plan allocates enough resources. We also question the flexibility of the prevention initiatives with respect to the ability of health care professionals to respond to the challenges and opportunities that exist in preventing disease. We believe that much more effort needs to be placed on prevention activities.

Once a SIDS episode occurs, there is no medical procedure, operation, or drug, that can be administered to bring a SIDS baby back to life. The only way to stop SIDS is to understand it -- and prevent it from happening.

Federal SIDS Initiatives

Mr. Chairman, there are three major federal initiatives occurring currently that address Sudden Infant Death Syndrome. How we view health care reform can be gauged by how these major initiatives are impacted by the various proposals.

- 1.) **The SIDS 5 Year Research Plan** - The National Institute on Child Health & Human Development is the major agency conducting SIDS research through the 5 Year Research Plan. The SIDS Alliance recommends that the prevention initiative in the health care reform proposal be flexible enough, and funded adequately to support a dramatic acceleration of research into preventing Sudden Infant Death Syndrome. Preventing SIDS and reducing infant mortality must be major priorities in health care reform.
- 2.) **Death Scene Protocol** - 50 different states in this country have at least 50 different ways of conducting the investigation at the scene of an unexplained infant death. SIDS parents living the real nightmare of the death of their baby have also had the unfortunate experience of spending that same night in jail, as a result of a lack of standard protocol for what should occur at the scene of an unexplained infant death. Later this year the Centers for Disease Control and the National Institutes of Health, will issue a recommended Standard Death Scene Protocol to states in hopes that they will be adopted on a state by state basis. The standard protocol will be more sensitive to grieving parents and attempt to collect the best information to be used in gaining further understanding about SIDS.
- 3.) **SIDS Services** - Each of the 7,000 SIDS deaths annually leave 7,000 sets of parents, siblings, grandparents, and friends desperate for answers and in need of professional support, counseling, and bereavement services. Mr. Chairman, until we can prevent SIDS, more discretionary resources must be dedicated to SIDS services. There should be more emphasis on helping a family struggle through this crises that might leave the SIDS victim's 3 year old sister wondering, "Will I die tonight ?" Instead, SIDS service programs around the country have been virtually wiped out with the advent of block grants. The Health Reform proposal does focus more funding on public health crisis, and prevention, but maternal and child health services, such as SIDS services come up short. The availability of these support services are essential to families who have lost a child to SIDS.

Thank you for the opportunity to present the views of the SIDS Alliance. I would be happy to answer any questions that you may have at this time.

Chairman STARK. Thank you.
Mr. Stoddard.

**STATEMENT OF TOM STODDARD, MEMBER, BOARD OF
DIRECTORS, AMERICAN FOUNDATION OF AIDS RESEARCH**

Mr. STODDARD. Thank you very much, Mr. Chairman. We appreciate greatly the opportunity to appear before you today.

I speak now on behalf of the American Foundation for AIDS Research, on whose board of directors I sit. AmFAR is the Nation's largest private funder of AIDS research.

I speak, too, in two other capacities today. As a lawyer, I represented John McGann in his well-known lawsuit against an employer in Houston, the H&H Music Company, that altered its plan after he got sick to exclude the illness he had, namely, AIDS. You may remember that the U.S. Supreme Court declined review of that case upon the advice of the previous administration.

And I should add, because I think it is important in this setting, that I speak also from a personal perspective. I myself have AIDS, and have had a diagnosis of full-blown AIDS for more than 4 years.

People with AIDS and other life-threatening or catastrophic illnesses worry about all aspects of the reform package. We insist upon universal coverage. We wish to see a prohibition of exclusions based upon medical history or type of illness. We ask for portability and uniformity, and we ask for coverage for the entire continuum of care, including long-term nursing care.

Although we have concerns in all areas of the package, I would like to limit my remarks today to the benefit package, specifically prescription drugs, because of their special importance to people situated as I am.

The administration's proposed benefit package appropriately emphasizes preventive care. Preventive care for people like me, for people with AIDS, means by and large drugs. Drugs are the only way now to sustain life and to postpone the onset of symptomatic illness. Drugs now, I am happy to say, can lengthen life and can limit suffering, even though there is no cure for AIDS. I know this fact personally very well.

Today I will take 24 pills. Over the course of the next 4 weeks, I will receive from 3 to 5 infusions: One to fight *Pneumocystis carinii* pneumonia, which is still the leading cause of death for people with AIDS, and two to combat a kind of skin cancer called Kaposi's sarcoma. These medications have saved my life. Without them I would not be here today. But they are very expensive.

The pills alone cost \$1,200 a month. The intravenous treatments cost more than \$1300 a month. Quick arithmetic indicates an astounding figure. I must pay or someone must pay on my behalf more than \$30,000 a year simply for drugs, without medical care. These medications have allowed me to stay alive.

We must have a system that permits people with HIV and other difficult-to-treat illnesses, to have full access to all the medications they receive.

I am one of the lucky ones; I have insurance. Many people with AIDS and similar circumstances are no longer employed, lose their group health insurance, and cannot obtain the drugs that they

need. We must have a system that assures them access to the full range of drugs and treatments now available..

I therefore urge that there be a severe limitation or, indeed, an elimination of any provision for copayments. I also urge that the President's proposal to include off-label use of drugs be sustained, because in an illness like AIDS where the standard of care is constantly evolving, doctors must be able to use all of the weapons at their disposal to sustain life.

I would be irresponsible in not pointing out that with an illness like AIDS, where there is no known cure or treatment, ultimately government research and continued funding of research at an adequate level will save lives.

Thank you very much.

[The prepared statement follows:]

**TESTIMONY OF TOM STODDARD
ON BEHALF OF
THE AMERICAN FOUNDATION FOR AIDS RESEARCH**

**THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
OF THE UNITED STATES HOUSE OF REPRESENTATIVES**

NOVEMBER 15, 1993

Good morning. I speak today on behalf of the American Foundation for AIDS Research (AmFAR), on whose Board of Directors I sit. AmFAR is the nation's leading private funder of AIDS research, having given more than \$65 million to 1,300 researchers to study both the basic science of HIV and the treatment of the disease, as well as strategies for prevention and education.

I also speak from a personal perspective. I myself have AIDS.

I should add that as a lawyer, I represented John McGann in his highly publicized lawsuit to secure medical benefits from his employer, H&H Music Company in Houston, which changed its health care plan after he got sick by placing a \$5,000 disease-specific cap on AIDS. The case highlighted all too clearly the mechanisms used to deny people with AIDS health care and the extremes to which they must often go to seek a remedy.

I thank you for the opportunity to appear today to discuss the Administration's health care reform proposal, especially its package of benefits.

Chairman Stark, AmFAR is particularly pleased to appear before you today in light of your personal commitment to a comprehensive, national health care program.

The problems that people with HIV must face serve as a prism through which all of the problems of our health care system can be seen. Moreover, if health care reform adequately meets the needs of people with HIV, it will meet the needs of all Americans.

As I have mentioned, the debate over health care reform is, for me, anything but abstract. What ultimately emerges from this chamber, as well as the Senate, will touch me every day for the rest of my life. And it will touch the lives of the more than one million other Americans living with HIV.

People with HIV and AIDS and those with other chronic and life-threatening illnesses, as major consumers of health care, worry about all aspects of the reform package. We believe that the system must assure universal coverage, that it must prohibit exclusions based on medical history or type of illness, and that it must provide both portability and uniformity. Moreover, we insist that the package cover the entire continuum of care from prevention to treatment to long-term care and that it include all conditions, including treatments for substance use and mental health.

Although our concerns are broad, I will focus today's remarks on the need for a comprehensive benefits package, particularly prescription drugs and the vital link between research and care.

Drugs are the primary weapons in the arsenal against AIDS. For people like me, lack of access to drugs guarantees imminent death. Access to knowledgeable doctors and nurses has little benefit if the drugs they prescribe are, as a practical matter, unavailable.

We know that preventive medicine is a fundamental pillar of the Administration's reform package. For people with HIV, preventive medicine means drugs, more than anything else. Drugs stave off pneumonia and blindness and fungal infections. They lengthen our lives and limit our suffering. They also save money, for the alternative to drugs is hospitalization.

I know this fact too well. Today, as I do every day, I will take 24 pills. Over the course of the next four weeks I will also receive three powerful drugs into my veins -- one to fight Pneumocystis carinii pneumonia (the leading cause of death for people with AIDS) and two to combat Kaposi's sarcoma, a form of skin cancer. These medications have enhanced my life beyond measure. Since my diagnosis with AIDS four years ago, I have yet to be hospitalized. Indeed, without the drugs, I would almost certainly be dead.

Yet they are very expensive and well beyond the reach of most Americans without health insurance. The pills alone cost approximately \$1,200 each month. The intravenous treatments cost another \$1,300 per month. The annual total cost of all of these medications comes to an astounding \$30,000.

Compared to the alternative -- hospitalization -- these medications are cheap, however. Consider Bactrim. Bactrim, which is the most effective treatment against Pneumocystis carinii pneumonia costs about \$50 a month, for an annual cost of \$600. The alternative -- hospitalization, for one episode of pneumocystis -- costs between \$10,000 and \$25,000.

More importantly, these medications greatly enhance day-to-day life. They keep people like me active and productive, rather than confined to a bed in a hospital.

I am one of the lucky ones. I still have insurance that covers prescription drugs. Although I am disabled and therefore unemployed, my last employer had an insurer -- Empire Blue Cross-Blue Shield -- that permits conversion from a group policy to an individual policy after the period of COBRA coverage expires. Most group policies are not convertible to individual policies. And most people in my circumstances eventually lose their insurance entirely after they leave their employment. For some of them, the consequence is the practical unavailability of the drugs needed to save their lives.

Members of the committee, for people with HIV, full and comprehensive coverage for drugs is a necessity. We will accept nothing less.

We must eliminate the barrier that copayments for prescriptions present. For a person with AIDS of moderate means, who must typically take ten medications or more simultaneously, copayments could mean having to choose between medication and food.

The off-label use of drugs must also be covered. With a new and difficult disease like HIV, the standard of care evolves constantly. Doctors who treat HIV must be able to prescribe the course of treatment most likely to sustain life. We should make certain to preserve this feature in any new health care package.

Ultimately, of course, the well-being of people with HIV depends upon this government's commitment to research. HIV has been recognized for only 12 years, but medicine has already learned how to slow down the progress of the disease in most people. Further advances -- and, in the end, a cure -- are achievable, but only with commitment and dollars.

Thus, I ask today for two things: commitment to research and commitment to universal access to the benefits of that research. Only with that access, can health care reform fulfill its promise to me and to the more than one million other Americans fighting this disease.

Chairman STARK. Thank you.
Mr. Isbell.

STATEMENT OF MICHAEL T. ISBELL, DIRECTOR, AIDS PROJECT, LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

Mr. ISBELL. Mr. Chairman, good morning. Thank you again for the opportunity to speak.

I am director of the AIDS Project of the Lambda Legal Defense and Education Fund, a national organization that advocates on behalf of people living with HIV infection.

Having experienced firsthand the deficiencies of our current system of health care financing, the communities most affected by AIDS warmly welcome introduction of the Health Security Act and applaud the President and Mrs. Clinton for showing overdue national leadership. It is our hope that the national debate that has begun will ultimately produce meaningful reform, and we look forward to working with the White House and with this committee to help achieve this objective.

People with HIV are acutely aware that existing systems of health care financing are founded on internal inconsistencies. Medicaid rules, for example, ostensibly obligate States to offer benefits in sufficient amount, duration and scope, yet State discretion subjects Medicaid recipients in many parts of the country to severe limits on allowable drug prescriptions, hospital days and doctor visits.

Internal inconsistencies are evident as well in the Federal ERISA statute, which theoretically forbids covered plans from discriminating against beneficiaries, yet which has been construed to permit plans to impose severe caps or exclusions on AIDS coverage.

The Health Security Act's likely impact on these historic contradictions remains unclear. With certain exceptions which time does not permit me to explore here, the act's standard benefits package includes most of the critical services required by people with HIV. The act also includes elaborate due process provisions empowering patients to challenge a health plan's denial of care.

Section 1402 of the act, however, authorizes health plans to take any prohibited action short of intentional discrimination if necessary to the normal operation of a health plan. For managed care plans, which form the centerpiece of the Health Security Act, normal operation has historically meant restrictive drug formularies, utilization review, and limited choice of provider, precisely the sorts of practices that have frequently forced people with HIV to go to court.

Under section 1141, medical necessity would form the touchstone for consumer rights under the Health Security Act. Yet, this vague term has not protected Medicaid recipients in the past. Numerous courts, for example, have held that a State satisfies the medical necessity test if benefit restriction does not disenfranchise the bulk of Medicaid recipients, a majoritarian approach that effectively sanctions discrimination against the chronically ill.

To achieve real reform, we must forgo the present system's penchant for letting the courts sort through competing consumer and administrative interests. If we are finally to recognize quality health care as a right in this country, the Health Security Act must expressly provide that the entitlement of each consumer to health care access transcends competing administrative or financial imperatives.

Thank you.

[The prepared statement follows:]

**Testimony of Michael T. Isbell, Esq.
 Director, AIDS Project, Lambda Legal Defense and Education Fund
 Subcommittee on Health, House Ways and Means Committee
 November 15, 1993**

Mr. Chairman, Honorable members of the Committee. My name is Mike Isbell. I am director of the AIDS project of the Lambda Legal Defense and Education Fund, a national organization that advocates on behalf of people living with HIV infection.

Having experienced first-hand the deficiencies of our current system of health care financing, the communities most affected by AIDS welcome introduction of the American Health Security Act. It is our hope that the national debate that has begun will ultimately produce meaningful reform, and we look forward to working with the White House and with this Committee to help achieve this objective.

People with HIV are acutely aware that existing systems of health care financing are founded on internal inconsistencies. Medicaid rules, for example, ostensibly obligate states to offer benefits in sufficient amount, duration and scope, yet state discretion subjects Medicaid recipients in many parts of the country to severe limits on allowable drug prescriptions, hospital days, and doctor visits. Internal inconsistencies are evident, as well, in the federal ERISA statute, which theoretically forbids covered plans from discriminating against beneficiaries yet which has been construed to permit plans to impose severe caps on AIDS coverage.

The Health Security Act's likely impact on these historic contradictions remains unclear. With certain exceptions that time does not permit me to explore here, the Act's standard benefits package includes most of the critical services required by people with HIV. The Act also includes elaborate due process provisions empowering patients to challenge a health plan's denial of care.

Section 1402 of the Act, however, authorizes health plans to take any prohibited action short of intentional discrimination if "necessary to the normal operation of the health plan." For managed care plans, which form the centerpiece of the Health Security Act, normal operation has historically meant restrictive formularies, utilization review, and limited choice of provider, precisely the sorts of practices that have frequently forced people with HIV to go to court.

Under Section 1141, "medical necessity" would form the touchstone for consumer rights under the Health Security Act, yet this vague term has not protected Medicaid recipients in the past. Numerous courts, for example, have held that a state satisfies the medical necessity test if benefit restrictions do not disenfranchise the bulk of Medicaid beneficiaries, a majoritarian approach that effectively sanctions discrimination against the chronically ill.

Although the Health Security Act would cover every American, many observers fear that the Act's complicated provisions for multiple high- and low-cost plans within given regions might ultimately result in the isolation of most elderly, low income and chronically ill patients in low-cost HMOs. Experience with Medicaid managed care suggests that concentration of poor consumers into a single tier of managed care would not significantly improve health care outcomes for poor Americans.

To achieve real reform, we must forego the present system's penchant for letting the courts sort through competing consumer and administrative interests. If we are to recognize quality health care as a right in this country, the Health Security Act must expressly provide that the entitlement of each consumer to health care access transcends competing administrative or financial interests. Thank you.

Chairman STARK. Thank you.

I have several concerns about the proposed plan, and you might each want to address one of them.

The administration in its design of alliances and the accountable health plans in a alliance, appears to allow the health plans, very clearly, to redline, to restrict their geographic coverage and decide when their plan is full, and thereby restrict free entry to the plans.

It wouldn't be much problem for me to be able to draw a plan certainly in the San Francisco area that might be restrictive and affect AIDS patients. Indeed, I wouldn't have much trouble finding healthier children in some communities than others if I were drawing the lines for a plan.

The other issue that concerns me is that there is a very, in my opinion, strong bias toward so-called managed care plans, and even the so-called choice of fee-for-service appears to me to be very restrictive. Because if your physician isn't on the choice or fee-for-service panel, beneficiaries are subjected to a higher copay, so that I find in it a strong bias toward so-called managed care and I am not sure whether all of you are comfortable with that or not.

And as between those two, the third item is this idea of limiting costs by capping premiums and thereby putting the responsibility for cost limits on the gatekeepers, insurance companies. Those are three of my principal concerns.

Why don't we just go down the line and see how each one feels about these issues. If none of those concerns trouble you, you can pass.

Dr. REDLENER. Thank you, Chairman Stark.

Actually, the one quick point about the alliances and whether or not the alliances and/or the plans will be able to restrict access to those plans or to declare a plan full, is to me entirely dependent on the nature and the strength of the assurances that are built in the governance structures of those plans. And I would suggest that if those are felt—

Chairman STARK. Let's differentiate between the alliance, which is the governing body, and the plans, the insurance companies running an HMO or an IPA or whatever.

Dr. REDLENER. Exactly.

Chairman STARK. The plans have the absolute ability to restrict themselves geographically. That is in the law.

Dr. REDLENER. Yes. But the alliances and the governance of those alliances will help determine, and very strongly so, how the plans will function and whether they can function in ways that will restrict access as far as my reading is concerned.

Chairman STARK. No, no, only price. And in some the dissemination of quality information, if you think that your patients can read it and understand it, but other than that, that is all there is.

Dr. REDLENER. Well, I would suggest that if in fact the Congress feels that those particular provisions are not strong enough or do not adequately protect populations who may be at risk or who have special needs, then I would suggest that the possibilities of strengthening those issues is entirely within your purview and I would be strongly supportive of that.

On the other hand, the point I wanted to make, having thought about this for a long time and having been in private practice and

now many, many years dealing with very underserved populations, is that the fee-for-service system where people, providers get paid for encounters, is absolutely—and I underscore this as strongly as possible—no panacea for delivering health services to the underserved.

And in fact, single-payer, episodic kind of care in the private, you know, offices of physicians, is absolutely no panacea about quality of care delivery either.

As a matter of fact, the issues around quality, around organizing health care, around doctors working in medical teams to provide better care and extended services, all of those are in fact not well served by a current fee-for-service, private-practice-based system for which I have many, many concerns with particular reference to underserved populations.

Chairman STARK. How would you like to comment on the combination of the worst of two worlds, fee-for-service managed by gatekeepers under an IPA managed care model where the incentive is to not refer? How do you like that?

Dr. REDLENER. Well, what we are currently living with is a very extreme version of exactly what you just mentioned, with increasingly limited choice of provider. The other issue that you brought up before, which is absolutely germane, but we are now well down a path that has extraordinarily limited choice for more and more people and will be doing so in the future.

And I believe that this issue about whether gatekeepers will function to reduce care that is needed by people, because they are trying to reduce costs, the only way to address that as far as I am concerned is to make sure that both—that providers and consumers, and particularly consumers, have a significant amount of information about medical outcome, about patient satisfaction, and so forth. And that is the challenge for us whether we have single-payer fee-for-service, or we have the Clinton plan. Both plans would be challenged to provide issues around quality of care to consumers.

I suggest that even as a private consumer, you don't have a clue, you don't, nor I do, about the overall quality of services provided by the hospitals or even the doctors we go to.

Chairman STARK. How many of your patients can pronounce, spell, or understand 1 in 10 of the procedures that you prescribe or do to them?

Dr. REDLENER. Well, I suggest to you that because my patients are poor or underserved or whatever is no reason why they—

Chairman STARK. If they are rich and have a Ph.D. in physics, how many of them know what it is that you are doing or understand the procedures or the protocol that you are engaging in?

Dr. REDLENER. Mr. Chairman, thousands and thousands of my colleagues every single day have no problem whatsoever explaining all sorts of things to patients, and to assume that parents cannot understand issues around quality of services delivered, or access to care, is not true. And I tell you this as a provider who for 23 years has been dealing with every manner of patient population from the poorest to the—

Chairman STARK. Do you think that somebody who is healthy and hasn't had an encounter can sit down and has the foggiest idea

of what they are apt to need as they look at this list of who does what? For example, do you think the patient who has good proctoscopic examinations, who gives a good cholesterol screening, or who gives this, or who gives that: do you think they are going to know what the hell they need if they haven't been sick?

Dr. REDLENER. Not only do I think it is absolutely possible, but if we don't do it, there is no plan on earth, whether it is single-payer or managed competition, that will be able to provide patients with the things they need to know about health care.

Chairman STARK. What is wrong with them asking their doctor? That is what they have been doing for 200 years.

Dr. REDLENER. They will ask their doctor, but the doctors don't necessarily know the answer.

Chairman STARK. If the doctor doesn't know, do you suppose the patient is supposed to know?

Dr. REDLENER. Yes, that is true. I will be happy to explain that to you.

Chairman STARK. No, we are out of time now.

Dr. Saunders, do you want to—

Dr. SAUNDERS. Well, I think what I would suggest is that the most significant issue with managed care or any revision of the health care system is accountability. And I think that was alluded to by the prior panelists. But I think what is inherent in the Clinton plan, I think also needs to be strengthened, is an accountability system that will monitor key performance indicators, such as the things you indicated, immunization rates in children, numbers of visits, outcomes of visits, and that sort of thing, so we can hold plans and alliances accountable—

Chairman STARK. You like the plans and alliances?

Dr. SAUNDERS. I am sorry?

Chairman STARK. You like the plans and alliances structure?

Dr. SAUNDERS. Well, it is certainly one option.

Chairman STARK. That isn't what I asked you. That is what we are trying to figure out. We have a thousand options in front of us. Do you like the President's alliances and plans structure?

Dr. SAUNDERS. Yes, I think that structure could work in there is in fact—

Chairman STARK. That is what I wanted to get to. But you don't mind the idea of limiting the costs by capping health insurance premiums or the payment to a plan, you think that is a good way to limit cost?

Dr. SAUNDERS. I am not sure I am in a position to comment on how to limit the cost, Mr. Chairman.

Chairman STARK. OK. Mr. Moran.

Mr. MORAN. I will pass, thank you.

Chairman STARK. OK. Mr. Stoddard.

Mr. STODDARD. Mr. Chairman, we are very grateful for your expression of concern about the possibility of redlining and limitation of choice. They mirror ours exactly. I have had some experience as an all-too-frequent consumer of health care on the issue of freedom of choice. If, for example, I could no longer go to the physician who now attends me, I could not receive one particular antiviral drug because it is still experimental and I receive it as a participant in a drug protocol; few doctors are enrolled in that protocol.

Chairman STARK. Can you buy those drugs in Mexico?

Mr. STODDARD. No, Mr. Chairman, my drug is available only through experimental protocols conducted by the manufacturer. My doctor is involved, as a number of doctors around the country are, in the investigation of the safety and efficacy of the drug. But for me the drug is a therapy treatment. If I left my current doctor, this drug would no longer be available to me even if it were the most effective antiviral.

The issue of expertise is also especially important within the context of HIV. HIV is a relatively new disease. It is one about which not everything is known, to say the least. Some doctors keep up with the data, others do not. Many doctors simply couldn't, because they have too many other issues and too many other patients to deal with. People with HIV have to go to doctors who understand HIV and keep up week by week with developments in research and treatment.

My drug regimen is changed every month. Some things are added, some things are subtracted, some things are modified in some fashion. My doctor, who has a large HIV practice, keeps up. Most physicians do not know or cannot. And that is a problem, especially outside large cities with a large caseload of people with HIV.

Chairman STARK. Do any of you have friends who are not familiar with the problems of HIV and AIDS or would you say that they have a good understanding of the therapies and procedures that are available to somebody who is diagnosed with HIV?

Mr. STODDARD. Fellow patients?

Chairman STARK. No, people you meet socially or in your profession.

Mr. STODDARD. Well—

Chairman STARK. You think that is pretty general knowledge abroad in the land about the kinds of treatments and procedures that people who get sick have available to them?

Mr. STODDARD. No, Mr. Chairman, even most physicians do not know, really, how to treat HIV unless they keep up with the literature. And the literature changes week by week and month by month, because of the novelty and difficulty of this particular illness. So freedom of choice has a special importance to people with HIV and similar diseases.

Chairman STARK. Thank you.

Mr. Isbell.

Mr. ISBELL. Mr. Chairman, your concerns are precisely our own. If I could address both of them, I think they reflect some of the problems which I mentioned in my testimony, and that is the tendency of the plan to incorporate certain internal contradictions, the first with respect to redlining. The ability of plans to cover only a portion of an alliance presents that precise problem.

In the metropolitan area of New York where I am from, for instance, my guess would be that if this plan is enacted as is, there would be multiple plans serving Westchester County, but only one plan serving Central Harlem. We know that, for instance—

Chairman STARK. Maybe.

Mr. ISBELL. Maybe. We know from an official task force report issued by the insurance commissioner's office of the State of Cali-

fornia that, for instance, there is one mammoth HMO in metropolitan Los Angeles that covers every ZIP code in the region with the exception of one, which happens to be West Hollywood, a heavily gay enclave. So, in fact, we know that if we permit plans to cover only a portion of an alliance, redlining is likely.

Now, at the same time, the plan provides that both government and individual patients may challenge a plan that engages in discriminatory conduct. Now, would that include redlining? It is not clear. But I think that this reflects the contradictory nature of the plan. On the one hand, providing patients with meaningful ability to challenge plans—

Chairman STARK. I think our first legislation in redlining for banks and insurance companies was back in the late 1950s. You can tell how much success we have had in 40 years.

Mr. ISBELL. Exactly. And that is precisely—

Chairman STARK. That is only dealing with money.

Mr. ISBELL. That is precisely our concern. In our view on the issue of redlining, it seems to me imperative that we demand that plans cover the entire alliance.

On the second issue with regard to managed care, most AIDS advocates have long felt that managed care is not the ideal delivery system for people with HIV. Such concerns center on the lack of specialists in many HMOs, the lack of—the absence of gatekeepers or the lack of—the failure to provide patients with choice of gatekeeper physicians with relevant expertise, compensation schemes that encourage undertreatment and the like.

Now, again, the plan provides fairly elaborate due process provisions. In addition, the Secretary of Health and Human Services, working with the Department of Justice, may decertify or exclude plans that incorporate practices designed to discourage enrollment by people with particular diseases or people with a particular health status. But by using or concentrating so heavily on the model of managed care, you once again incorporate an internal contradiction.

I think it is important that the plan includes a point-of-service option and a fee-for-service option. Our concern, however, is that for chronically ill or low-income patients, that it is extremely likely that in virtually every alliance the vast majority of such patients will wind up in a single low-cost HMO. Our experience with Medicaid managed care suggests that such a result will not significantly improve health care outcomes.

I think the challenge for this committee and for Congress as a whole is to try to prioritize among competing imperatives, to make sure that consumers have meaningful access to care under this act.

Chairman STARK. Are you familiar with how HIV positive patients are treated in Canada or Germany? Are there long waiting lines, rationing of care?

Mr. ISBELL. I am not intimately familiar. I do know that the vast majority of HIV medical spending occurs in this country. I am not frankly familiar with data from Canada or Germany with respect to outcomes or anything of the like in comparison to American HIV positive patients.

Mr. STODDARD. Well, we should add that the circumstance is somewhat different in Western Europe and Canada because the numbers are so much lower.

Chairman STARK. Thank you.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

To the two physicians on the end there, I have a question and I think that it is another way of coming at the question that Congressman Stark has raised with you. If you understood the President's plan to be one in which an accredited health plan, once it had a certain number of people, could say we can't take any more, we can't handle any more, and the alliance will now assign you to a health plan, do you have any fears that you will wind up with an accredited health plan that is basically a poor people's plan?

Dr. REDLENER. Yes, I definitely have fears that that might happen. And I am desperately concerned about the issue of us developing a two-tiered or multiple-tiered system that will be providing care on the basis of socioeconomic status of individuals or other even more onerous classifications of why people go into one plan versus another.

But the issue of either a plan or an individual doctor's office being full is something that would have to be addressed no matter what kind of system we have. And, you know, if you have in any given area a plan that has reached capacity, say, and they are saying, Look, we cannot handle any others, I am assuming that other plans will be developed or that patients will still have a choice of the remaining plans in that area.

It is inconceivable to me that the fact that one plan, say, out of a dozen in a large metropolitan area is full, that that would automatically trigger somebody being assigned to one of the other plans arbitrarily. I am assuming that there would still be choice to go into that plan, into another plan, or the following year when a person can change plans, that they will have a chance to go into the plan that they originally wanted if there is a vacancy there.

If in fact they are doing such a good job that lots of patients want to go to them, you know, it would suggest to me that other plans, either funding and supported by insurance companies or hospital organizations and physician groups, will do whatever they are doing, whatever the first one was doing, to similarly attract patients.

So the question, though, about will plans be able to say I am not taking in essence patients with a particular kind of illness or from a particular socioeconomic status, those plans should be and can be prohibited from doing so with appropriate structuring of the assurances by which those—

Mr. MCDERMOTT. I don't think anybody is suggesting that they would be able to openly discriminate. The question is, if you are full already, you don't want to expand, you take what you have, and therefore you discriminate by saying we won't take anybody new, you can keep out those people who would come with one illness or from one area of the city.

Dr. REDLENER. That might be. I am just suggesting to you that that problem would result in no matter what kind of health care system we have, and in fact occurs today with the offices of private

practitioners who decide that their panels are full and in essence do the same thing. I just don't—I think that can be dealt with by organizing strategies that would allow plans to expand capacity or require them to expand capacity, depending on which direction the alliance wanted to go.

Dr. SAUNDERS. Congressman, let me just add one other point. I think you are on the right track. There is also a provision in the plan as I understand it that requires Medicaid for AFDC recipients to contract with the lowest cost or a plan that has a cost less than the average. And I think that provision as well will further exacerbate the problem that you are describing, is that while it created a two-tiered system with low-income Medicaid recipients gravitating to low-cost plans and not being able to get in other plans that may either be full or may be by this provision in the proposal not willing to take or not able to take these clients. So I think that could further exacerbate the point you are making of a two-tiered system.

Mr. McDERMOTT. Could I then presume both of you don't want a two-tiered system? And I do have your agreement on that, right?

Dr. REDLENER. Yes.

Mr. McDERMOTT. You want one system for everybody, same level of care. And I understand that you want to support the President's plan.

For a minute, allow yourself to design the delivery system for the people who live in the inner cities of this country. What do you think that system, given what you know, given that you reject the idea of the single payer where somebody has a card and can go anywhere with it because you believe that leads to episodic visitation to doctors and no control over whatever or the continuity of care. How would you design the system to deal with the inner cities of our country?

Some 35 percent of the people live in the inner cities and the rural areas, and we know managed competition isn't going to work in either one of those places. I don't think anybody in their right mind thinks that there has going to be any competition in the South Bronx or in West Garfield Park in Chicago where I went to medical school, or in any of the places around the country where we have inner city problems.

So how would you design that system so that you could get the best quality health care for them without having them consigned to the poor people's HMO?

Dr. REDLENER. Well, first of all, I totally agree with the point that you are making, and in fact worked in the South Bronx, and would suggest that what is going to happen in areas like the South Bronx, like South Central Los Angeles and other places around the country, is that the large medical centers, the traditional providers of care to the inner cities, will themselves form large networks, as we are actually seeing as we speak in New York City.

The Montefiore Medical Center, in its association of hospitals, clinics, special services and practices, will be forming as a network to provide care in those areas. Similarly, New York Hospital, many other institutions are doing exactly the same thing.

Mr. McDERMOTT. Are they buying doctors' practices to develop their network?

Dr. REDLENER. In the case of Montefiore, they are establishing satellite community health centers.

Mr. McDERMOTT. They are doing it through the community health center mechanism?

Dr. REDLENER. Yes, yes. In some situations there are hospital networks that are in essence buying up doctors' practices, all of which are an attempt to create these networks that are being suggested by the plan.

Mr. McDERMOTT. That is what is going on in Seattle. Providence Hospital has bought 200 practices over the last year. So they are busy building themselves a network in the city. And I would like to hear how it is going in New York.

Dr. REDLENER. Well, in New York actually, in at least two examples, that is New York Hospital, Cornell Medical Center, which has recently purchased 15 or 16 larger facilities and other kinds of practice situations, and Montefiore Medical Center in the Bronx, both of those systems are busily involved in the development of these large networks that will in essence be able to provide the entirety of the health benefits package within their system, and in doing so, coordinate and organize care so that specialty services, special extended service, outreach programs, and so forth, can all be coordinated, organized and structured in such a way that poor people and people who have significant health care needs are able to get those needs in a nonepisodic but coordinated fashion, and I think will be good for their care and for their needs.

Mr. McDERMOTT. Are you suggesting that Montefiore would be one of the accredited health plans in New York?

Dr. REDLENER. Yes, I would.

Mr. McDERMOTT. How many people do you think that they could reasonably serve?

Dr. REDLENER. I don't know, but—and I think the—what you are implying is absolutely a concern of mine also, which is that, you know, I am dealing in a city where there are at least 300,000 or 400,000 children that do not have regular access to a comprehensive medical home type environment. There aren't enough resources in New York currently to fill those needs—and I am just talking here about the children; I am not even talking about people with chronic illnesses, people with HIV, older people who are not getting health services adequately.

So there is no question that the other half of this plan which we have not talked about much, which is the entire reinforcement and enhancement of the public health structure, new moneys for developing new facilities and new practices, new satellites of the systems enabling service structures, new national health service corps moneys and new community health center moneys, are all absolutely essential to making sure that underserved rural and urban areas get what they need to get, which is something additional to what we have now.

There is no question that just the alliance plan structure is unable by itself to solve the underserved challenges in this country. But neither would single payer, for example. Any plan that says we are going to have universal care must have in it a very strong, well funded and secure funding base for the development of new health services. No matter how you lay it down, they are going to have

to appear from somewhere, and hopefully the President's plan addresses most of that in that portion of the bill.

Dr. SAUNDERS. I would just echo some of that, in that having a health card by itself, especially for those vulnerable populations in the inner cities, East Garfield Park, for example, in Chicago, or in rural areas, is not enough. And as he is indicating, I think the support services, the enabling services, the case management, the outreach, and the other social services to augment the medical care, if you want to really see outcomes.

For example, in Illinois, we have seen that in such places as East St. Louis, or in fact in Garfield Park where they have even dramatic improvements in health status by a combination of good medical care, good access to medical care, but also good support services for low-income and vulnerable populations such as pregnant women and infants and children, and disabled individuals with special needs.

So I think you are right, we need to focus on the benefit package, but also on some of these public health structure issues that are currently unfunded in the plan but are critical if we are going to see improvements in health status and improvements in access to care for low-income and vulnerable populations.

Mr. McDERMOTT. I would only suggest that for your reading on the plane home, you take a copy of H.R. 1200 and look at the public health sections in there. We put in a lot of money in there because it is my belief that the inner cities do require a reinforcement and a substantial augmentation of what is currently available. The World Health Organization has just put out a report on tuberculosis, and what is happening in an epidemic connected to United States HIV-AIDS.

As you look at those issues, you realize that the public health sector is a tremendously important part of any system. You will never deal with everybody through the private health care system without a real augmentation of the public health system.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank the panel very much for their participation.

Our next panel consists of Warren Greenberg, who is a member of the Mended Hearts, American Heart Association; Dr. Alfred Munzer, president of the American Lung Association; Abbey Meyers, who is the executive director the National Organization for Rare Disorders; Dr. James Gavin III, president of the American Diabetes Association; Linda King Aukett, who has president of the United Ostomy Association, Digestive Diseases National Coalition; and Val Bias, who is the chairman of the board of the National Hemophilia Foundation.

We will ask Mr. Greenberg to lead off, as soon as we get your name tags up there so we know who we are dealing with.

Mr. GREENBERG. May I start?

Chairman STARK. Please.

**STATEMENT OF WARREN GREENBERG, PH.D., MEMBER,
MENDED HEARTS, AMERICAN HEART ASSOCIATION, AND
PROFESSOR OF HEALTH ECONOMICS AND HEALTH
SCIENCES, GEORGE WASHINGTON UNIVERSITY**

Mr. GREENBERG. Thank you very much.

On behalf of the American Heart Association, I would like to thank the subcommittee for affording me the opportunity to be here today. I am Warren Greenberg, a member of the Mended Hearts, an AHA affiliated support group of 22,000 individuals throughout the United States who have heart disease.

I was born with a defective heart valve. I have had two open heart surgeries to replace my valve, and if it were not for preventive services, I would not be here today.

I am also a Professor of Health Economics and of Health Care Sciences at George Washington University, and have written or edited nine books on health policy and health economics.

The American Heart Association is a nonprofit, voluntary health organization funded by private contributions. The goal of the association is to reduce disability and death from cardiovascular diseases and stroke. To support this goal, the AHA has contributed more than \$1 billion to cardiovascular research and has developed educational programs designed to promote health and to prevent and reduce the risk of heart diseases and stroke.

I am here to testify on the need for coverage of basic cardiovascular care and specific preventive health care benefits in a basic health care benefit package. The position of the American Heart Association to date on health care reform has been guided by five principles on access to health care, which are attached to my testimony and which we feel are critical to any health care reform package. We are pleased that the President's plan contains provisions addressing all these principles.

We are also pleased to hear the President and the First Lady talk about many of the objectives contained in our five principles, particularly the high priority given to preventive health care benefits.

The focus of today's hearing provides the perfect opportunity to discuss the AHA's third principle of access to health care; that is: Coverage for preventive care must be part of any proposal for health care access, and that there is a critical need to have preventive health services made available to all Americans.

We believe that prevention can have a major impact on the health of the American people. This is especially true of heart disease and strokes because of the considerable available knowledge about methods to prevent them. And unlike many organizations that will testify at the numerous hearings on health care reform, the AHA has no special interest or for-profit motivation. What guides its position and policy are 250 million Americans who are candidates for cardiovascular disease and stroke.

As you know, Mr. Chairman, the two diseases, which are the number one and number three killers of Americans, account for over 930,000 deaths each year. We know that behavioral modification can reduce these deaths, and preventive health services provide the most effective means of behavioral modification.

We have developed a package of preventive cardiovascular services which we believe should be a part of basic medical coverage. The benefit package that is attached to my testimony today has been approved by AHA's Science Advisory Council. Our preventive package reflects accepted procedures and principles for the prevention of cardiovascular diseases. The National Heart, Lung and Blood Institute's national cholesterol education program, released in June of this year, confirms the AHA's recommended preventive services package.

If the current health care reform debate stresses the implementation of preventive measures, we can have a major impact on the health of the individual as well as the public. The AHA believes that a basic medical plan should include the following basic cardiovascular preventive services: Blood pressure checks, cholesterol screenings, electrocardiograms, exercise stress tests, counseling and medications.

We do not believe every procedure should be available upon demand. The attached document provides in detail when and for whom these procedures should be done.

I would like to stress the importance of counseling at the primary care level. Periodic preventive counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium and caloric balance, and the need for a regular exercise program is critical. For those people at high risk with high cholesterol levels, we recommend a diet therapy with monitoring and long-term followup with a physician, registered dietician or licensed nutritionist be covered under the health plan. Preventive services can also make a large impact on recurrence of disease in those who have already had a heart attack or surgery.

The AHA urges the committee to ensure that the coverage is available for secondary preventive services, namely treatment after an angioplasty. We believe that patients who have already been treated for cardiovascular disease should have health care coverage for diet counseling, drug therapy counseling, rehabilitation, smoking cessation and exercise counseling.

Providing coverage for counseling on tobacco prevention and cessation is also very important to the AHA. Tobacco use is the number one preventable cause of death in the United States, and we know that most smokers would like to quit but cannot. We also know that smoking cessation programs work. We are presented with a great opportunity right now to provide the encouragement to quit that smokers need. That, coupled with increased excise taxes, would have a tremendous impact on tobacco use in this country.

Mr. Chairman, other members of the panel, prevention, both medical and educational, has an integral role to play in health care reform. The AHA has public education programs to inform people how to reduce the risk of heart disease. These efforts would be greatly complemented by a comprehensive health care plan, accessible to all, that includes preventive cardiovascular health care, as outlined in the attached document, and I thank you very much for your time and consideration.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF WARREN GREENBERG
AMERICAN HEART ASSOCIATION**

On behalf of the American Heart Association, I would like to thank the Subcommittee for affording me the opportunity to be here today. I am Warren Greenberg, a member of the Mended Hearts, an AHA affiliated support group of 22,000 individuals throughout the United States who have heart disease. I am also a professor of health economics and of health care sciences at the George Washington University.

The American Heart Association is a non-profit, voluntary health organization funded by private contributions. The goal of the Association is to reduce disability and death from cardiovascular diseases and stroke. To support this goal the AHA has contributed more than one billion dollars to cardiovascular research, and has developed educational programs designed to promote health, and to prevent and reduce the risk of heart diseases and stroke.

I am here to testify on the need for coverage of basic cardiovascular care and preventive health care benefits in a basic benefit package. The position of the AHA on health care reform, to date, has been guided by our five principles on Access to Health Care, which are attached to my testimony, and which we feel are critical to any health care reform package. We are pleased that the President's plan contains provisions addressing all of these principles. We are also pleased to hear the President and the First Lady talk about many of the objectives contained in our five principles, particularly the high priority given to preventive health benefits.

The Administration has clearly taken a leadership role in setting the tone and direction for the debate on health care reform. It is clear that the Administration is committed to improving health care for all Americans, and we are greatly appreciative of all the work, effort, and sincerity that the Administration has given to this issue.

The focus of today's hearing provides the perfect opportunity to discuss the AHA's third principle of Access to Health Care: "Coverage for preventive care must be part of any proposal for health care access", and that there is a critical need to have preventive health services made available to all Americans.

We believe that prevention can have a major impact on the health of the American people. This is especially true of heart disease and stroke because of the considerable available knowledge about methods to prevent them.

The need for access to preventive services is plain in the face of the fact that there are 250 million Americans who are candidates for cardiovascular disease and stroke. As you know, Mr. Chairman, these two diseases, which are the No. 1 and No. 3 killers of Americans, account for more than 930,000 thousand deaths each and every year. The leading cause of death among women in the United States is cardiovascular diseases, killing more women than cancer. We know that behavior modification can reduce these deaths and we know that preventive health services provide the most effective means of behavior modification.

As advocates for people who suffer from cardiovascular diseases and their families, we are pleased that we are seeing progress in research, education and healthier lifestyles. Unfortunately, we still face daunting problems:

- o In 1990, heart and blood vessel diseases killed more than 930,000 Americans--more than two out of every five deaths.
- o Of the current U.S. population of about 250 million people, more than 70 million suffer some form of cardiovascular disease, in many cases with a reduction of the quality of life.
- o Heart diseases and stroke are not only a threat to the elderly. More than 161,000 Americans under the age of 65 die from cardiovascular disease each year.
- o Cardiovascular diseases and stroke cost are estimated to be \$117.4 billion in 1993, which includes \$75.2 billion for hospital and nursing home services; \$17.9 billion for physician and nurse services; \$6.7 billion for drugs; and 17.6 billion in lost productivity.

In the past three decades, great strides have been made in the prevention and treatment of heart disease with a resulting decline in the cardiovascular death rates, mainly attributed to lifestyle changes. But, since up to 50% of heart attack victim's first warning is sudden death, there is little opportunity for treatment, and prevention offers the only hope.

In 1990, an estimated 392,000 coronary artery bypass procedures were performed on 262,000 patients at an estimated expenditure of over \$9 billion dollars. Should all heart attack prone individuals be treated surgically, resources to defray the costs would not be available. This is true, even more so, for heart transplants, which constitute a frequent treatment for end-stage heart disease. The technological treatments for heart disease such as angioplasty, thrombolytic therapy, antiarrhythmic drugs, and pacemakers are not curative. More importantly, such procedures can do nothing about the underlying process, atherosclerosis (the hardening of arteries), which is the principal cause of the problem.

It seems obvious that more effort should be directed to preventive approaches. Atherosclerosis begins in young adulthood and it may be decades before clinical disease is manifest. While we do not fully understand all of the causes of heart disease, large epidemiologic studies have identified risk factors and strategies to reduce the risk. These modifiable risk factors include high total cholesterol levels in the blood, cigarette smoking, hypertension, and physical inactivity.

There has been a significant reduction in cardiovascular mortality in the U.S. due, in large part, to the public's adopting a more healthful lifestyle. This underscores the importance of encouraging the medical profession to assume a preventive posture. More and more evidence is accumulating showing that atherosclerotic plaques in arteries can regress even in individuals with advanced disease.

Unlike many organizations that will undoubtedly testify at the numerous hearings on health care reform, the AHA has no special interest, or for-profit motivation. What guides our position and policy are the 250 million Americans who are candidates for heart disease and stroke.

We have developed a package of basic preventive cardiovascular services that we believe should be a part of basic medical coverage. We are pleased to see that President Clinton's plan specifies coverage of clinician visits for preventive care and we offer our expertise on the type of benefits to be included under the auspices of clinician visits. The benefit package that is attached to my testimony has been approved by the AHA Science Advisory Committee, and it reflects accepted procedures and principles for the prevention of cardiovascular diseases. The National Heart, Lung and Blood Institute's National Cholesterol Education Program (NCEP)'s Adult Treatment Panel II update, released in June of this year, confirms the AHA's recommended preventive services package.

The AHA believes that a basic medical plan should include the following basic cardiovascular preventive services: blood pressure checks, cholesterol screenings, electrocardiograms, exercise stress tests, counseling and medications. We do not believe that these procedures should be provided to everyone on demand; the attached document details when and for whom these procedures should be done.

I would like to stress the importance of counseling at the primary care level. Periodic preventive counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium, and caloric balance and the need for a regular exercise program is critical. For those people who are at high risk with high cholesterol levels, we recommend that diet therapy with monitoring and long-term follow-up by a physician, registered dietician or licensed nutritionist be covered under the health plan.

Preventive services can also make a large impact on recurrence of disease in those who have already had a heart attack or surgery. The AHA urges the committee to insure that that coverage is available for secondary preventive services, namely, treatment after an angioplasty. We believe that patients who have already been treated for cardiovascular disease should have health care coverage for diet counseling, drug therapy counseling, rehabilitation, smoking cessation and exercise counseling. Clearly, secondary prevention measures are highly cost effective, as well as an essential treatment for patients who we know are in trouble.

I would also like to draw the Subcommittee's attention to the importance of prevention of hypertension and the Fifth Report of the Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, commonly referred to as JNC V. For people who are at high risk for the development of hypertension, such as African Americans, persons with high normal blood pressure or with a family history of hypertension, the report recommends moderation of sodium intake, reduced consumption of calories, regular physical activity, and moderation of alcohol consumption.

Coverage for counseling on tobacco prevention and cessation is also very important to the AHA. In Title I of President Clinton's revised plan, Section 1114 describes coverage for clinician visits for preventive health care. We interpret clinical preventive services to encompass tobacco prevention, and would urge the Subcommittee to clarify that smoking cessation counseling should be included in the basic benefit plan.

Tobacco use is the leading cause of preventable death and disability in the United States. We are presented with a great opportunity right now to provide the encouragement that smokers need to quit. According to the Centers for Disease Control and Prevention, each year tobacco use kills 418,000 Americans, and burdens our health care system with \$68 billion in direct medical costs and lost productivity. Tobacco use is linked to heart disease, high blood pressure, stroke, cancer of the lung, larynx, trachea, pancreas, bladder and lip and respiratory diseases. Smokers also have increased problems with colds, pneumonia, influenza and bronchitis.

Furthermore, when it comes to tobacco and the prevention of disease, we are no longer solely concerning ourselves with the smoker. As you know, in January of this year, the EPA released a report that concluded that environmental tobacco smoke (ETS) has a serious and substantial impact on the non-smoker, and therefore our nation's public health. ETS is now listed as a known human carcinogen along with asbestos, benzene, and arsenic. The EPA report found that children who are exposed to ETS are at a higher risk for lower respiratory tract infections, ear problems, and new and increased symptoms of asthma. The AHA estimates that 35,000 to 40,000 cardiovascular disease-related deaths occur each year as a result of ETS.

Mr. Chairman and members of this Subcommittee, we must do more to protect our citizens and particularly our children from the ravages of tobacco. After allowing the tobacco industry to control the tobacco and health agenda in Congress for the last 40 years, the opportunity exists for "change." Do not let the tobacco industry hold health care reform hostage to its special interests. Too many Americans have died because Congress has failed to act. Many more will die if Congress does not intervene.

Mr. Chairman, prevention--both educational and medical--has an integral role to play in health care reform. The AHA has public education programs to inform people how to reduce their risk of heart disease. Countless numbers of posters, brochures, booklets, advertisements and kits targeted to schools, businesses and health care sites reach millions of Americans every year with educational messages promoting good heart health. The AHA's community service programs educate the public on how to control high blood pressure, stop smoking, adopt healthy dietary habits and be physically active.

These efforts will be greatly complemented by a comprehensive health care plan, accessible to all, that includes preventive cardiovascular health care as outlined in the attached document.

President Clinton has emphasized the need for preventive care research as a part of his health care reform proposal. The AHA believes that the allocation of funds for biomedical research is pivotal to any health care reform plan.

Without continuing research, we will not be able to improve the diagnosis and treatment of cardiovascular diseases. We will only make critical advances if biomedical research, research training and clinical training are recognized as integral parts of health care reform.

We recognize, as well, that biomedical research is essential to the development of preventive measures. Recent developments in molecular and genetic cardiology indicate that the near future will present the opportunity for highly cost-effective preventive interventions, targeted to high-risk individuals with identified genetic predisposition to disease, before the development of clinical disease states. An early example will be familial hypercholesterolemia.

The AHA wants to participate in the development of guidelines for appropriate, quality cardiovascular care and see more research on methods to measure quality, outcomes and cost-effectiveness. We believe that professional groups, such as the AHA, should be an important part of guideline development. Proper, effective and cost efficient care is necessary if the United States is going to find a solution to the health care crisis we are facing today.

The American Heart Association, in conjunction with the American College of Cardiology, has already developed ten practice guidelines on procedures ranging from electrocardiography to exercise testing to coronary angiography and by-pass surgery. The AHA and ACC are currently working on additional guidelines. The AHA would be happy to provide copies of guidelines to the committee at your request.

Death rates from heart attacks, among both men and women, have gone down substantially in the last twenty years. These statistics are the result lifestyle changes by the public and advances in medical technology and therapy. Health care providers play an important role identifying people at high risk for cardiovascular disease and encouraging them to modify their behavior. However, there is much to be done in the area of outcomes research. The New England Journal of Medicine notes that "further research about the overall risk-benefit ratios of these interventions and the development of effective strategies to help implement risk-factors modifications are needed."

The AHA is prepared to assist the committee as it proceeds in the health care reform debate. We will be happy to provide you with more information on any of our programs at your request.

Chairman STARK. Dr. Munzer.

STATEMENT OF ALFRED MUNZER M.D., PRESIDENT, AMERICAN LUNG ASSOCIATION, AND ALSO ON BEHALF OF THE AMERICAN THORACIC SOCIETY, AND DIRECTOR, OF CRITICAL CARE AND PULMONARY MEDICINE

Dr. MUNZER. Good morning, Mr. Chairman and members of the subcommittee. I appreciate the opportunity today to address the content of a standard benefits package.

I am Dr. Alfred Munzer, director of critical care and pulmonary medicine at Washington Adventist Hospital and president of the American Lung Association, and I am appearing today on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society, a 10,000 member professional organization of physicians, scientists and other health care professionals specializing in pulmonary medicine and lung research, the American Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 310,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. A little over 3 years ago and in part because of these grim statistics, we began deliberating the issue of health care reform, looking at the issue from the specific perspective of the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective boards of directors of our two organizations and a copy of our policy statement is included with this testimony.

We support guaranteed access to care with coverage that is uniform, comprehensive, portable, and that encourages continuity of care and eliminates consideration of any kind of preexisting condition. Our statement provides details of what we believe a standard package should look like and gives examples of pulmonary-specific benefits.

In the area of preventive benefits, we recommend that influenza immunization be provided for all at risk individuals regardless of age, not just as currently proposed, those over the age of 65. We believe that there should be a mechanism in place to allow for frequent changes in immunization indications, and we believe that asthma education and asthma self-management must be covered under health education.

We are also pleased to see that President Clinton has included smoking cessation and other preventive benefits under the category of health education. Smoking costs the United States at least \$65 billion each year in health care costs and lost productivity. There is no way that we will put a cap on health care expenditures unless we put a lid on tobacco use, and, therefore, we also strongly support a \$2 excise tax on tobacco products.

We recommend a wide range of outpatient benefits in chronic and rehabilitative care that are outlined in detail in my statement. I hope you will look at that statement, and I thank you very much

for allowing us to be a part of this very important and very crucial debate.

Thank you, Mr. Chairman.

Mr. McDERMOTT [presiding]. Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF ALFRED MUNZER, M.D.
PRESIDENT
AMERICAN LUNG ASSOCIATION**

Chairman Stark and members of the Subcommittee, I appreciate the opportunity today to address the content of a standard benefits package. I am Dr. Alfred Munzer, Director of Critical Care and Pulmonary Medicine at the Washington Adventist Hospital, and President of the American Lung Association. I am appearing today on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 310,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. That rank may change. The lung disease death rate is climbing steeply, while the rates for America's first- and second-ranked causes of death, heart disease and cancer (except for lung cancer), are dropping. From 1979 to 1990, the lung-disease death rate rose by 20.6 percent, while the death rate from heart disease fell a dramatic 23.8 percent.

A little over three years ago, and in part because of these grim statistics, the ALA/ATS began deliberating the issue of health care reform, looking at the issue from the unique perspective of the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective Boards of Directors of the two organizations. A copy of our policy statement is included with this testimony. We support guaranteed access to care with coverage that is portable, and that prohibits any kind of pre-existing condition exemption. Our statement also provides details of what we believe a standard benefits package should look like, giving examples of pulmonary-specific benefits. A chart detailing that discussion is located on page 3 of our attached policy statement.

The ALA/ATS support a uniform package of basic benefits that includes the appropriate levels of preventive, acute, chronic, and rehabilitative care. Although we do not specifically include long-term care benefits in our position paper, we would also support the inclusion of long-term care benefits in a basic benefits package.

PREVENTIVE BENEFITS

ALA/ATS Recommends that:

- * influenza immunization be provided for all at-risk individuals, regardless of age,
- * a mechanism be in place to allow for frequent changes in immunization indications, and
- * asthma education and asthma self-management be covered under health education.

We are pleased to see that President Clinton has included the influenza vaccine and pneumonia vaccine in the preventive benefits section of his reform package. However, we are concerned that the influenza vaccine would only be provided to those individuals age 65 and over. In years such as this current year, when the strain of influenza is expected to be unusually severe, we recommend that ALL individuals at-risk get their influenza vaccine, not just those over 65.

Others at-risk include:

- * health care workers of all ages;
- * residents of nursing homes and other chronic-care facilities housing persons of any age with medical conditions;
- * adults and children with chronic cardiovascular or respiratory disorders, including children with asthma;
- * adults and children who have required regular medical follow up or hospitalization during the preceding year because of diabetes mellitus or other chronic metabolic disorders, kidney dysfunction, blood disorders, or the immunosuppression that can be caused by AIDS or various cancer treatments; and
- * children and teenagers -- from 6 months to 18 years -- who are receiving long-term aspirin therapy, and therefore may be at risk of developing Reye syndrome after influenza.

We recommend that influenza immunization be available to all at-risk populations. The pneumonia immunization is probably appropriate for those age 65 and over. However, as indications for immunization can change frequently, it is important to maintain flexibility. There must be a ready mechanism in the benefits plan to deal efficiently and effectively with these types of necessary changes.

We are also pleased to see that President Clinton has included smoking cessation and other preventive benefits under the category of "health education." Tobacco is the only product that, when used as intended, causes disease and death. 419,000 deaths a year are attributed to smoking. The morbidity and mortality associated with second-hand tobacco smoke raise the stakes even higher. Maternal smoking during pregnancy accounts for an estimated 20 to 30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and some 10 percent of all infant deaths. Smoking costs the United States at least \$65 billion each year in health care costs and lost productivity. As a further preventive health measure, we strongly support increasing the excise tax on tobacco products by \$2 per pack.

The ALA/ATS recommends that other health education benefits such as asthma education and asthma self-management be included in the preventive benefits package. Asthma is, in fact, the most frequent reason for hospitalization due to chronic disease in children and teens under age 15. Asthma is also the number one cause of school absences attributed to chronic health problems. If students are taught how to manage their asthma -- what triggers an attack, how to avoid those triggers, what to do should an attack occur, and how to effectively use their medications -- trips to the emergency room, hospitalizations, and lost school days can be reduced significantly.

CHRONIC CARE AND REHABILITATION BENEFITS

ALA/ATS Recommends that:

- * a wide range of outpatient benefits be provided,
- * oxygen benefits be retained under Durable Medical Equipment,
- * a national coverage policy be established for home oxygen use, and
- * criteria be ensured for rehabilitation services to allow for maintenance or nondeterioration in condition.

Lung disease doesn't always kill. It may simply make each breath barely possible--a constant, moment-to-moment struggle to stay alive. Nearly 26 million Americans are now living -- often painfully -- with chronic lung disease. At least 15 million suffer from chronic obstructive pulmonary disease (COPD), the fifth-ranking cause of death. COPD includes emphysema, which afflicts approximately 1.6 million Americans, and chronic bronchitis, which affects nearly eight times as many -- 12.5 million people.

Classic emphysema develops over many years of assault on lung tissues. Breathing falters and, ultimately, each breath becomes a chore. In the end, patients are dependent on oxygen, even at rest. The damage, and the disease, are irreversible. In most cases, therapy is limited to relief of symptoms and attempts to improve the patient's general quality of life.

Like emphysema, chronic bronchitis typically develops over many years. Many of those who suffer from it are subject to periodic attacks of obstructed breathing, when their lungs become inflamed and clogged.

Sarcoidosis can attack any organ of the body, but it most frequently affects the lungs. Pulmonary sarcoidosis causes stiffness in the lungs and a decrease in the amount of air the lungs can hold. Although the disease can be found throughout the world, it is particularly prevalent in middle-aged, African Americans. If a case of pulmonary sarcoidosis becomes serious, it can develop into pulmonary fibrosis -- the abnormal formation of fiber-like scar tissue in the lung. This distorts the structure of the lungs and can interfere with breathing. This can result in yet another chronic lung disease, bronchiectasis, in which pockets form in the air tubes of the lung and become sites for infection. Corticosteroid drugs are the primary treatment for sarcoidosis.

Asthma is another chronic lung disease. An attack finds the victim gasping for breath as the airways become constricted. Between 1979 and 1991, the hospitalization rate for asthma rose 24.2 percent. The reasons for this increase are currently unknown but are the subject of extensive scientific investigation. For those who suffer from asthma, treatment typically means a variety of medications, some used regularly to stave off trouble, other to counter acute attacks. They include bronchodilators, corticosteroids and other reducers of inflammation, and a variety of agents designed to minimize allergic reactions. Complying with often complex treatment regimens can prove particularly difficult for children.

Although lung transplantation may be an option for some patients with endstage lung disease, it certainly is not appropriate for all patients with chronic respiratory-related diseases. Most medical care for diseases such as sarcoidosis, and severe COPD, involve proven, highly effective treatments such as periodic physician visits, drug therapies, supplemental oxygen, and, for some, pulmonary rehabilitation. For many of these patients, support groups, health education classes and in some cases, psychological counseling, may be necessary to help teach patients how to live with their disease, and cope with the changes in their lifestyles. Such chronic or "maintenance" benefits are the reality that help these patients live a relatively normal life in their own home.

We recognize that durable medical equipment is covered under President Clinton's plan. We recommend that this include, as has been the case in the past, the administration of supplemental oxygen and supplies needed by many chronic lung disease patients. However, the ALA/ATS would like to see a national coverage policy with respect to home oxygen use. Even within the Medicare program, there is no national, uniform coverage policy. This gap creates unnecessary confusion for the patient and the providers over what treatment is covered for which diseases and symptoms.

The ALA and ATS would also caution that all forms of successful rehabilitative care do not necessarily affect the outcome of the patient's condition. For patients with chronic lung disease, the major benefits of pulmonary rehabilitation are improvements in quality of life. The objectives of pulmonary rehabilitation are to control and alleviate symptoms and complications and to achieve optimal ability to carry out activities of daily living. Pulmonary rehabilitation may consist of a variety of activities from exercise training to increase breathing capacity, to breathing retraining, energy conservation and nutrition counseling. For many patients, rehabilitation keeps them at an even level, but more importantly it prevents further deterioration in their condition. We hope that such assistive rehabilitations are not lost in the move to cure all patient ills.

ACCESS TO SPECIALTY CARE

ALA/ATS Recommends that:

- * appropriate and timely access to specialty care be preserved.

Although the American Lung Association and the American Thoracic Society support the need to train more primary care providers, we are concerned that lung disease patients have access to the appropriate specialty care their condition demands. A gatekeeper system that too strictly requires permission/referral for every visit to a specialist would be a large detractor to access for people with chronic lung conditions. Appropriate management of moderate to severe asthma or sarcoidosis by a specialist, for example, is more likely to result in fewer hospitalizations than care of those same cases by a general internist or family practitioner who does not have the extra, necessary training. For many patients, specialists ARE their "primary care provider." In fact, pulmonary physicians are well trained to assume full care for the patient whose primary problem is lung-related.

BENEFITS DISCLOSURE

ALA/ATS Recommends that:

- * **health plans provide full disclosure of benefits.**

Once the benefits package is established, health plans must be required to disclose the full spectrum of benefits, including any additional benefits that may be provided. It is important for individuals, such as people with asthma, to know that they will have access to the range of benefits they need to maintain a healthy life-style, including the correct pharmaceuticals, nebulizers, peak flow meters, spacers, tubing, asthma education, and so forth. These benefits must not only be fully disclosed, but also defined in easy-to-understand terms. Patients must be able to comprehend exactly what they are receiving, or more importantly, be assured that they will receive the benefits they need.

SUMMARY

In summary, Mr. Chairman, the ALA/ATS supports a full continuum of benefits, appreciating the emphasis on prevention, ensuring coverage of benefits for people with chronic conditions to help them maintain a quality of life within the parameters we term "normal," and guaranteeing access to specialty care as is appropriate. Patients must also be made aware of what the full benefits package includes, in detail, and the information must be presented in a way that is comprehensible to the average person.

**Position Statement
of the
ALA/ATS Health Care Policy Task Force**

**REFORM OF THE U.S. HEALTH
CARE SYSTEM**

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society — a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research — the Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Based on this mission, we believe our health care system must meet the multiple needs of people with lung disease. It is widely recognized that far too many people are without access to even the most basic of health care services in our current health care system. This structure, therefore, does not meet the needs of people with lung disease or other diseases existing in our society today.

A strong national medical research agenda as well as an effective medical education program are critical to our health care system. However, after considerable discussion, the Task Force agreed that this document was not the proper place to consider these significant yet slightly tangential issues.

The ALA/ATS believes that patients (consumers of health care) and deliverers of health care must have an effective voice in the health care reform debate. As advocates for persons with lung disease and representing people who deliver health care, we therefore call on Congress and the federal government to enact comprehensive health reform that takes into account the principles outlined in this document. We recognize the complexity involved in these proposed changes and the need for a structure to represent the diverse constituencies to implement the changes.

ALA/ATS POSITION STATEMENT ON HEALTH CARE POLICY

The ALA/ATS supports the development of a health care system that will meet the special needs of patients with lung disease based on the following criteria:

ELIGIBILITY

ALA/ATS POSITION: *Health care is a right. Our health care system(s) must guarantee access to a basic level of services for all residents of the United States regardless of employment status, ability to pay, pre-existing condition or other factors such as, but not limited to, age, gender, sexual orientation, or racial or ethnic background.*

We believe health care is a right to which individuals are entitled by virtue of their existence. We recognize and separate this right from those rights that are guaranteed through the Constitution of the United States and the legal system of the United States. Residents of this nation must not be excluded from the health care system for any reason.

Although we believe all U.S. residents must have access to the health care system, we recognize that parameters must be set with regard to the breadth of services provided. For that reason, we support a basic level of health care services to which all residents are entitled. Unfortunately, the United States simply does not have the resources to guarantee unlimited health care coverage to all individuals.

COVERAGE AND BENEFITS

ALA/ATS POSITION: Comprehensiveness — *The basic level of services must be the same for all individuals. These services include appropriate levels of preventive, acute, chronic, and rehabilitative care, and must be provided so as to preserve continuity of care. Access to these services must continue regardless of the cause of illness, or an individual's employment, physical, mental, geographic, or financial state.*

ALA/ATS POSITION: Quality of Care — *The basic level of services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team. Timely means without delays that would otherwise adversely affect the outcomes of care.*

ALA/ATS POSITION: Basic Level of Services — *These services should be broad-based and the same for all individuals. Services to be provided are listed on the following page.*

BASIC HEALTH CARE SERVICES TO BE PROVIDED

	<u>Basic Health Services</u>	<u>Pulmonary-Specific Examples</u>
Preventive	Prenatal care Well baby/well child Family planning services Childhood immunizations Adult immunizations Education Periodic health examinations Effective therapies for at-risk populations	TB skin test Appropriate testing for congenital processes (cystic fibrosis, alpha-1 antitrypsin deficiency) TB prophylaxis Influenza, pneumococcal vaccine Smoking cessation programs Pentamidine aerosol (HIV) Screening for occupation- and environment-related pulmonary problems Routine and complaint-specific clinical evaluations
Outpatient	Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy Prescription drugs	Diagnostic evaluation: routine physical problem-directed history, physical examination Diagnostic testing: radiologic imaging, pulmonary functions Outpatient procedures: thoracentesis, fiberoptic bronchoscopy Ongoing treatment for chronic problems: chronic obstructive pulmonary disease -- COPD (chronic bronchitis, emphysema), cystic fibrosis, sarcoidosis, asthma, occupational lung diseases
Inpatient	Extensive diagnostic evaluation Complex treatment of both acute and chronic conditions	Follow-up for positive findings on diagnostic evaluation Treatment for serious exacerbation of chronic problem(s): COPD Treatment for serious exacerbation of acute problems: pneumonia
Rehabilitation	Physical therapy Occupational therapy Supportive care: nursing facilities, home care, durable medical equipment, respite, hospice Mental health services: substance abuse	Physical therapy Occupational therapy Respiratory therapy Pulmonary rehabilitation Supportive care: home care, chronic ventilator care, oxygen

STRUCTURE

We believe all societal barriers must be eliminated, including jurisdictional questions over coverage, so all individuals have access to the same, uniform set of services and that these services are portable. The guaranteed services should span the continuum of coverage from preventive health services including prenatal and pregnancy care, immunizations, and health screenings to acute services including inpatient hospital care and outpatient services, and chronic and rehabilitative care. In all cases, the services provided must be medically effective as defined through research findings; appropriate as determined by the patient, family and health care team; and timely — without delay due to financial or administrative barriers. We also realize that there are societal interests that may be affected in the provision of care.

ALA/ATS POSITION: We favor a health care system that is a pluralistic public/private payment and delivery system. Mechanisms must be established to facilitate the requirement of employers to finance the health care benefits of their employees and employees' dependents. Supplemental benefits can be provided in whole or in part by the employer, or purchased privately by the individual.

We recommend that all federally-sponsored health care programs be consolidated into a single public plan.

We believe the new health care system should build upon our current public/private system. We support an employer mandated system in which mechanisms and incentives would be established to help employers finance health care benefits for their employees and the employees' dependents. Under this proposal, the employer could, for example, provide health care benefits directly as a self-insured program or purchase a group plan as long as the benefits financed by the employer include at a minimum all the services listed in the Benefits section on page 3. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own, if they so choose.

It may also be necessary to effect changes at the federal government level with respect to small market insurance laws (i.e., guaranteed issue, guaranteed renewability, community ratings) to facilitate employer compliance. In addition, procedures must be in place to ensure that health care services are provided in instances of jurisdictional coverage dispute (e.g., workers' compensation versus traditional insurance).

We strongly believe that all federally-sponsored health care programs should be consolidated into a single public plan that provides all the services listed in the Benefits section on page 3. This plan would include

SYSTEMIC AND PROVIDER CONCERNS

the Medicare program, Medicaid, Veterans' Administration health programs, CHAMPUS, community and migrant health programs, and so on. It would eliminate the duplications of administration and delivery of services among these many programs. It also would allow for a uniform public program that would not vary by state (as is the problem with Medicaid), and allow access to services regardless of the nature of the illness (as with the VA programs).

ALA/ATS POSITION: *Administrative* — *The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be standardized for all payers, thus maximizing resources for actual health care services.*

ALA/ATS POSITION: *Provider Reimbursement and Availability* — *Providers must be fairly compensated to ensure access to health care. This compensation should reflect provider cost, work, and time. Incentives must be developed to encourage an appropriate distribution between primary care and specialty physicians and a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.*

We believe the system must be "user friendly" and easily accessible to patients. We believe the administrative processes of the health care system must be simplified and standardized for all payers so that more of our health care dollars are spent in providing health care services, and less for paying salaries of people hired to fill out forms. Reforms in this area could include electronic filing of claims, a single uniform insurance form, or "smart cards" for individuals.

We also believe all providers of health care (physicians, nurses, nurse practitioners, clinical nurse specialists, physician assistants, allied health professionals, and hospitals) should be reimbursed at a fair rate so as to ensure full access for patients to all providers. We also believe incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in areas that are traditionally underserved. A strong primary care network must be developed to act as the entrance point for individuals into the health care system.

To achieve these goals, we make the following recommendations: Improve academic preparation in middle and high schools; provide financial incentives such as scholarships, loan forgiveness or tax credits; revise clinical curricula in medical school to emphasize ambulatory care; equalize compensation between primary care and medical specialties; and reform the malpractice insurance system.

INDIVIDUAL AND PUBLIC RESPONSIBILITIES

ALA/ATS POSITION: *Education for health is the responsibility of many sectors of society including employers, schools, families, religious institutions, health providers and voluntary health agencies such as the American Lung Association, the American Thoracic Society, and others. Individual responsibility for health is crucial to an effective health care system. Through proper education individuals will become empowered, active, and aware of their responsibility for positive health behavior and maintenance of healthy life styles.*

We believe strong, comprehensive health education programs are an integral part of preventive health care. These programs will encourage individuals to maintain healthy life styles and take responsibility for positive health behavior.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations and others to join the voluntary health community in providing comprehensive health education.

FINANCING AND COST CONTAINMENT

ALA/ATS POSITION: Financing — *The financing of universal health care should avoid placing an inappropriate burden on any individual or particular sector within society and will require a degree of government support. Any premiums, deductibles, and co-payments for the basic level of services should be uniform. An individual's ability to pay shall not be a barrier to care.*

ALA/ATS POSITION: Cost Containment — *An employment-based health care system of universal coverage can be economically feasible only if there are cost containment features that address both aggregate budget expenditures and provider payments and are applied to all payers.*

We believe the health care system should be financed through multiple sources, including the government, with no one sector or individual bearing an unfair or disproportionate share of the costs. We support a progressively financed system and believe that any premiums, deductibles, or co-payments required must be based on an individual's ability to pay.

Finally, we believe cost containment is essential for maintaining a "healthy" health care system and that a variety of tools can be used to rein in the spiraling costs of health care. We suggest tools such as outcomes research, the development of clinical practice guidelines, reform of the medical liability system, electronic submission of claims, a single uniform insurance form, and such other tools as necessary to address aggregate budget expenditures and provider payments.

ALA/ATS Task Force on Health Care Policy

James P. Baker, M.D., Chairman
Eastern Virginia Medical School
Norfolk, Virginia

Marilyn Abraham, R.N.
VA Medical Center
Tucson, Arizona

Jacqueline C. Flowers, M.P.H.,
M.Ed.
Associated Medical Schools
of New York
New York City, New York

Kevin Gibson, M.D.
University of Pittsburgh
Pittsburgh, Pennsylvania

Douglas Kelling Jr., M.D.
Concord Medical Services
Concord, North Carolina

Paul N. Lanken, M.D.
Hospital of University of
Pennsylvania
Philadelphia, Pennsylvania

Rev. H. Michael Lemmons
The Congress of National
Black Churches
Washington, DC

Diane Masseth-Jones, M.S., CHES
American Lung Association
of Orange County
Santa Ana, California

Terry R. Rogers, M.D.
King County/Blue Shield
Seattle, Washington

Linda Rosenstock, M.D., M.P.H.
University of Washington
Seattle, Washington

John J. Sheehan
United Steelworkers of America
Washington, DC

Peter G. Tuteur, M.D.
Washington University School
of Medicine
St. Louis, Missouri

Kevin Weiss, M.D.
George Washington University
Medical Center
Washington, DC

Mary Ellen B. Wohl, M.D.
Children's Hospital Medical Center
Boston, Massachusetts

Vincente S. Zapata, Ed.D., Dr.P.H.
California State University
Los Angeles, California

Ex officio:
Carl Booberg
American Lung Association
of Virginia

James D. Crapo, M.D.
President, American Thoracic
Society

John R. Garrison
Managing Director, American
Lung Association
New York City, New York

Lee B. Reichman, M.D.
President, American Lung
Association

Staff:
Robyn Henderson, coordinator
Judy Corn
Fran Du Melle
Marilyn Hansen
Shane McDermott

Mr. McDERMOTT. Ms. Meyers.

**STATEMENT OF ABBEY S. MEYERS, EXECUTIVE DIRECTOR,
NATIONAL ORGANIZATION FOR RARE DISORDERS, INC.**

Ms. MEYERS. I would like to apologize for having laryngitis. I know that—

Mr. McDERMOTT. Is that a rare disease?

Ms. MEYERS. I know President Clinton tried to make laryngitis a very fashionable disease, but, fortunately, I will recover with practically no expenditure and not even a visit from the doctor, which is unlike most rare diseases which are undiagnosed or misdiagnosed 1 to 6 years, on average, and about 15 percent of people are undiagnosed for more than 7 years. Once you finally get the diagnosis, it is outrageously expensive to get treatment in many instances or you have to fight with your insurance company for reimbursement because if you have no diagnosis, they do not know what to reimburse for.

The insurance industry treats us like cars, really, all Americans. Once you get sick, once you have an accident, you either have to pay higher rates or you lose your insurance, and that is what has to stop. The most important lesson that we found out of everything that has happened in the last few years is that there must be very strong Federal control; that the rules have to be set so that every State and community follows uniform rules. We know, for example, certain States are not following Medicaid rules that have been in effect for many years, because the Federal Government did not go in and enforce them.

The President's Health Security Act is the most important social legislation that will be enacted this century. Guaranteed universal coverage, community rating, elimination of preexisting condition exclusions are all extremely important, but most of all, people will be able to choose their insurance company.

Right now we really are limited to the insurance company that our employers provide for us. My written testimony describes several areas where the plan could be enhanced because it is basically geared toward saving on the treatments for most prevalent disorders, and that is the way it should be. If millions of people are taking antihypertensive drugs, saving a few pennies, for instance, on those types of drugs will save tens of millions of dollars. Unfortunately, though, the unique patients may continue to fall through the cracks and this is what worries us.

We have to find a way to allow the system, allow doctors to respond to those unique needs of people who may need a drug that is not at a local pharmacy, for example, and put those mechanisms into the law so that no one will be denied care.

Something has to be done about pharmaceutical prices. There is really no competition in that field, and if we have a law that sets up wonderful reimbursement mechanisms for diagnosis, it should really cover treatment with access to all kinds of drugs that are needed.

The problem is that only the bulk buyers of pharmaceuticals and the government, which is a bulk buyer, is able to purchase drugs at discounted prices now, and the money that is discounted for those sales is then cost shifted on to the retail pharmacy. So when

you and I, as customers, walk into a local pharmacy to get a prescription, we are paying much more than we should.

The health industries will also continue to find and oppose, and care should be taken to close as many loopholes as possible. We like the President's carrot and stick approach. The breakthrough drug committee has some problems with it, but the worst problem we see is the elimination of drugs under Medicare if they do not come to an agreement with the breakthrough drug committee. We would like you to find a way not to punish the patients if the drug company is charging too much, find a way to address that problem with the drug company, do not let it be the patient who suffers because prices are out of control.

We would also like you to look into things like compulsory licensing of drugs, like they have in Canada. There should be an absolute requirement that they charge no more in the U.S. than they do in other countries, and there should be enforcement powers for the most egregious abuses.

And we look forward to working with you in the future on finalizing this plan, but we urge you not to delay because so many people have been suffering without health insurance for so long. Thank you.

[The prepared statement follows:]

**TESTIMONY OF ABBEY S. MEYERS
EXECUTIVE DIRECTOR
NATIONAL ORGANIZATION FOR RARE DISORDERS**

Mr. Chairman, thank you for the opportunity to testify before your committee on what is perhaps the greatest social legislation for our nation in this century. Health care reform has represented an elusive promise that was first defeated in Congress in 1919, and it is our fervent hope that America will not end this century without affirming the very basic human right of guaranteed medical care for every citizen of the United States.

I am Abbey Meyers, Executive Director of the National Organization for Rare Disorders (NORD). NORD is an alliance of 127 voluntary health agency members and approximately 60,000 individuals who are dedicated to the identification, treatment and cure of rare "orphan diseases." Each of these disorders affects fewer than 200,000 Americans; but there are over 5,000 orphan diseases cumulatively affecting an estimated twenty million people in the United States.

These rare disease patients have suffered every injustice and every hindrance the current health care system has to offer. Not only do they have diseases that many doctors have never heard of much less diagnosed or treated, but their treatments are sometimes experimental and extremely expensive. To make matters worse, these patients are often denied insurance coverage because of pre-existing conditions. Once they obtain a diagnosis their insurance premiums may be raised exorbitantly, or they may be fired from their jobs because their health care expenses make an employer's insurance premiums unaffordable. Perhaps the ultimate and most degrading experience is when they are told by social workers or government officials that their only alternative is to divorce their spouses and go on welfare so they or their disabled child can receive Medicaid benefits. Our great and bountiful country, Mr. Chairman, can be a cruel and uncompassionate place for people who have the bad luck to get sick, especially with an uncommon disorder.

In summary, Mr. Chairman, rare disease patients suffer from everything that can go wrong with our health care system, and universal health care is not a luxury for these people, but a necessity. It truly is a matter of life or death.

President Clinton's Health Security Act therefore represents a major advancement in this nation's commitment to its citizens, especially the most vulnerable among us. Guaranteed universal coverage, community rating and elimination of pre-existing condition exclusions sounds like sacred words that we could heretofore utter only in prayer. Nevertheless we worry that the Clinton plan will be so heavily lobbied and there are such powerful forces arrayed against it, that it will be chewed up in the political grist mill and spit out sometime next year in a form that is hardly recognizable.

We ask you to focus on one factor during your negotiations on this bill: Please don't give us health care reform with cracks through which our patients will continue to fall. They have suffered enough, and the Congress owes it to every single American to assure that no one will be left out of the health care system ever again!

Many of our concerns have been addressed by the Clinton plan. For example, while prevalent

diseases such as arthritis, hypertension, etc., can be adequately treated locally, rare diseases often require very specialized care by physicians at academic research institutions. For some diseases there may be only one or two physicians expert enough to diagnose or treat the disease in the entire country. For example, the rare hereditary kidney disease, cystinosis, can kill children by adolescence unless they receive the appropriate treatment. Only three doctors in America specialize in this disease, and they have FDA's permission to provide the only treatment, which is an experimental drug. The drug has been experimental for twenty years even though there is substantial evidence that it is safe and effective. The fact is there are only about 150 children with cystinosis in the country, and no pharmaceutical manufacturer was willing to commercialize the drug until this year because it will obviously be unprofitable.

President Clinton also recognizes the importance of increased support for biomedical research, which is our lifeline to hope. Because there are over 5,000 rare diseases, the great majority of them are not being investigated because they have never achieved the level of political visibility attained by the more widespread diseases. Most rare diseases are genetic, and most healthy people feel they are not vulnerable to them. But the fact is we all carry some defective genes and every time a child is born the odds change as quickly as in a Las Vegas craps shoot.

No one is immune from a rare disease, and practically everyone who gets one of these "back of the text book" illnesses never believed it would happen to them. This is the very reason why every American must have health insurance.

We are somewhat confused, however, about the cost containment measures of the Health Security Act. The President has done an admirable job of utilizing spending caps and other mechanisms to reduce health care inflation. He attempts to bring downward pressure to bear on many facets of health care market prices, but there seems to be no controls for pharmaceutical costs.

Obviously, it would be a major mistake for us to create a health care system that covers prevention and diagnosis, but not treatment. Pharmaceuticals must be covered. But there is no mechanism in the law to inhibit price escalations in the pharmaceutical market except for the "Breakthrough Drug Committee" which has the power of persuasion and nothing else.

The United States is the last free market in the world for pharmaceuticals. Just about every other industrialized country controls the prices of drugs. We are convinced that, as a result, the pharmaceutical companies are cost-shifting the profits they do not make in France, England, Japan, etc., onto their American prices and that U.S. consumers are therefore subsidizing much of the world's drug development. It is time for the American government to tell the rest of the world that our citizens are unwilling and unable to support these costs, and other nations must pay their fair share. Moreover, American drug companies should not be spending a billion dollars a year more on marketing than they are on research and development of new drugs. In England, drug companies spend only 10% of their budget on marketing. Why aren't we moving to limit these unproductive expenditures here in the United States?

Mr. Chairman, we can understand why the President chose not to include drug price controls in his

package. It's a very sticky wicket, and with so much else of importance in the bill, it would not do to have this issue derail all the rest. Nonetheless, the issue of exorbitantly high drug prices is a tremendous deterrent to the health or recovery of many, many American patients, and we urge that the Congress re-examine aspects of this portion of the President's plan to see how they might be improved.

For example, it seems to us that under the bill the only real power the government would have to restrain drug prices is to prohibit Medicare reimbursement for new breakthrough drugs that come on the market with unfairly high prices. In principle, this is a provision that would seem to work to the advantage of rare-disease patients, since they are highly reliant on new drugs to treat diseases for which there currently are no treatments.

Yet, Mr. Chairman, if this provision merely results in such drugs being taken off the Medicare-reimbursement list entirely, the practical result will work against the patients. Then, only the well-to-do among them will be able to afford to buy these drugs at full price, with no reimbursement.

In other words, this provision seems to be written for the benefit of the government, instead of the patient, and we believe it should be looked at again. While we grant that savings to the government theoretically would make more money available for other aspects of the health plan, we think that the theory seldom works in practice.

By the same token, we question the mandatory 17% rebate for Medicare drugs, and we respectfully ask: Why not just tell the companies to reduce their prices by 17% - - and so give the benefit directly to the consumer?

Finally on the price issue, while we understand the political necessity of "voluntary" price restraints, we think they should be backed up by strong monitoring and by a strong determination to take sterner action if this voluntary approach fails. Indeed, we think this should be the approach applied to all areas of the health care market, not simply drugs.

We are pleased to see that reimbursement for "off-label" drug usage will be covered under the law because drug companies rarely agree to invest in the FDA required studies needed to add additional diseases to a drug's label. This is vitally important to rare disease patients since most are treated with drugs that were developed for other diseases.

However, the President's plan omits reimbursement for "medical foods", and this can be very harmful to people with certain metabolic diseases. For example, the plan covers mandatory nationwide testing of newborns for a disease called Phenylketonuria (PKU), but if PKU is diagnosed these children must avoid regular foods and eat only a special PKU formula, sometimes for the rest of their lives. If they eat normal food, they become irreversibly mentally retarded. However, the PKU formula can cost \$5,000 per year. Isn't it more expensive (not to mention inhumane) to support a mentally retarded person in an institution rather than avoid the disability in the first place?

There are diseases and congenital birth defects that can significantly alter the appearance of an individual. Medically necessary reconstructive surgery must be covered in the final plan for accident, illness and congenital defects where reconstructive surgery is necessary. Mr. Chairman, this is not intended for the person who feels his nose is too big, or her ears need to be pinned. This is for children who are born with congenital birth defects and need to have half their face replaced, or the person whose face is deformed due to an auto accident. These patients should be guaranteed access to reconstructive surgery enabling them to live a normal life.

We are very pleased that the President's plan addresses long-term care. Because many rare diseases are chronic, patients of all ages may need access to long-term care. Home and community-based services, as suggested in the President's plan, are certainly preferable to nursing home care. But the plan should ensure that people of all ages, even infants, will be cared for if they are seriously disabled, and there should be no time limitation for services, especially for children.

Durable medical equipment, prosthetics or orthotic devices are another area we were pleased to see in the plan. DME's and prosthetic and orthotic devices are needed for everyday life by many rare disease patients. This equipment is not cosmetic, but absolutely essential in assisting patients to lead normal lives. However, the President's plan omits custom-made prosthetic and orthotic devices, and this is a grave mistake. Why should a baby born without arms have to go without them because there are no "off-the-shelf" items that fit?

The President has gone to great lengths in his health reform legislation to protect computerized medical records, but there is no stipulation about pharmacy or physician records, and no punishment for releasing them. How would you like it if a drug company could find out that your daughter takes AZT for AIDS or your brother takes a drug for genital herpes? Or perhaps your colleague on this Committee is taking a prescription for psychotropic drugs to control his schizophrenia. Medical privacy should be a guaranteed right, and it ought to be written into this groundbreaking legislation.

Mr. Chairman, we recognize that the President's plan is aimed at addressing the most common health care problems where the greatest expenses occur, and the greatest potential costs savings can be made. And rightfully so. If you allow insurers to set up drug formularies, for example, and that insurer is buying anti-hypertension medications for millions of people, they will save millions of dollars by excluding the most expensive high blood pressure drugs from their formulary. Similarly, if you set up a long-term care program, you will naturally design it to address the needs of the elderly. However, the unusual cases will fall through the cracks because you cannot design a "one size fits all" system.

Let me give you examples: While millions of dollars could be saved by allowing every insurer to have its own formulary, in the case of my children who have Tourette Syndrome and are treated with a high blood pressure drug, what will we do if this particular drug is not on the formulary? Obviously, formularies will want to omit the highest cost drugs. What will people do if they need a biotechnology drug that is not on the formulary? We are certain that there will not be a biotech drug priced lower than \$10,000 per year, per patient, and one recently approved biotech product has been priced as high as \$350,000 per year. By omitting expensive drugs from formularies we

are punishing the patients, not the drug companies for their pricing.

In the case of long-term care under our current system, people can spend down to Medicaid and get nursing home coverage, which is primarily needed for the elderly. But we know of children with severe disabilities who need long-term care and have been placed in nursing homes with 85-year-old Alzheimer's patients because there is no place else to put them. Is this appropriate, and more importantly is it humane?

So we are asking this committee and all of Congress as you approach your compromises for the final legislation, please remember there are exceptions to the rules and please build in those escape hatches for the unusual cases. For example, if you allow formularies you must permit doctors to order drugs that are not on the formulary for some patients who may lack any treatment alternative, and you must create minimum standards that all formularies must abide by. Patients should be given a 72 hour supply of the drug in an emergency, and doctors should be guaranteed a 24 hour response from the insurer when they request an exception for a patient. Do not leave the patients out on a limb for weeks, waiting for the doctor to get an answer.

Even though we are concerned about some of the details, there is no doubt that the President's plan will meet the basic needs of all Americans. The plan is a good compromise between those who advocate for a single-payer system and those who want the current free market system to continue. But we live in fear that what it guarantees now will be substantially changed in the final version.

Mr. Chairman, every American accepts his or her responsibility to educate the young. We all pay school taxes. We do not tax larger families more to educate their children, and families without children are not excused from paying their school taxes. Why would guaranteed health care be less important than guaranteed education? Why do those who oppose this bill say we, the richest country in the world, cannot afford to do something that poorer countries guarantee to their citizens? We will have more choices under the Clinton plan than we do now because most of us have no choice but to accept the insurance policy that our employer gives us. And too many of us work for employers who do not offer insurance at all. Why should we have to pay more if we get sick, and why are insurers permitted to treat us like cars - you have an accident and you lose your insurance.

It is time to reform the health care system, and this time, Mr. Chairman, the American people mean it.

Mr. McDERMOTT. Thank you.
Dr. Gavin.

**STATEMENT OF JAMES R. GAVIN III, M.D., PH.D., PRESIDENT,
AMERICAN DIABETES ASSOCIATION**

Dr. GAVIN. Good morning. My name is Dr. James Gavin and I am the senior scientific officer for the Howard Hughes Medical Institute and president of the American Diabetes Association and, for brevity sake, I will hereafter refer to the association as the ADA.

The ADA is the Nation's largest voluntary health association representing the health care and medical research interests of more than 13 million people with diabetes and the health care professionals who serve them. Our mission is to prevent and cure diabetes and to improve the lives of all people affected by this disease.

I am pleased to share our views on the President's health care reform proposal. The ADA strongly supports the Clinton administration's efforts to reform the U.S. health care system. We especially endorse the general theme of prevention. The President's proposal addresses the general areas of concern outlined in the association's Statement of Principles on Health Care Reform, and those principles are: To ensure universal access to quality diabetes treatment; to prohibit preexisting condition exclusions; to provide coverage for prescription drugs and insulin, diabetes-related supplies, equipment, and education; and to mandate community rating.

Now, for our purposes, the timing of these hearings could not be better. Important outcome research has been done in diabetes. We are pleased that recent clinical trials and research studies have clearly shown that diabetes complications, including blindness, nerve disease and kidney failure, can be prevented or delayed by proper treatment. Thus, we feel that it is our obligation to ensure that the basic benefits package is defined to include access to appropriate diabetes treatment and management.

There are some areas we believe need to be clarified in the President's proposal. The proposal includes coverage for durable medical equipment, such as blood glucose meters. However, it is not clear that the necessary supplies, specifically test strips and lancets, are also included in the basic benefits package. The ADA believes that durable medical equipment and the supplies necessary for the proper maintenance and function of those items should be included in the basic benefits package.

Under the new Medicare benefits section, insulin is specifically included. Insulin must be administered by a syringe or by an infusion pump. These tools are as necessary as insulin itself for proper treatment. However, it is not clear whether the President's plan includes insulin syringes, infusion pumps and tubing under the new Medicare benefits section. Clearly, these items also need to be included.

Education, or self-management training, has been shown to be a critical component of diabetes control and maintenance. In order to improve outcomes and to prevent complications, people with diabetes must learn to administer insulin and/or other medications, monitor their blood glucose levels and adjust their diet and exercise habits to maintain good health.

Health education classes are cited in the President's plan, but the language indicates that health plans "may" offer such services. The ADA believes that health plans should be required to include diabetes outpatient self-management training services under the basic benefits package and under the Medicare benefits package.

In July, the State of New York adopted legislation requiring the inclusion of diabetes-related supplies, equipment and education in all policies written in the State. The ADA believes that such an important benefit should be included in any comprehensive national health care reform package.

In order to achieve adequate levels of self-management, people with diabetes require the services of a variety of health professionals in the management of their disease. The President's plan defines health professionals and health professional services for inclusion as a covered benefit, however, it is unclear whether these definitions include the services of dietitians and nurses. The ADA believes that the services of dietitians and nurses are an integral part of the diabetes health care team and should be included in the basic benefits package.

This disease costs more than \$91 billion annually in direct and indirect costs, and despite this enormous public health impact, our system fails to provide the necessary and effective preventive services for people with diabetes which can reduce these complications. The results of the Diabetes Control and Complications Trial, the DCCT, a multiyear study sponsored by the National Institutes of Health, shows in a definitive way that diabetes complications can be prevented or delayed for most people with Type I, or insulin-dependent, diabetes. These findings are important for all people with diabetes, but they will prove ineffective if their access to these services is denied.

Finally, the DCCT is a perfect example of the critical importance of Federal funding for basic research and clinical research. With the dramatic advances made in the field of diabetes research in recent months, I would be remiss in my duties as a physician and researcher if I did not acknowledge the contributions of the Federal Government in achieving these results. I would also be remiss if I did not say that we are firmly in support of health care reform.

The President's package contains much that is desirable for people with diabetes and other chronic diseases. While we feel there is more that might be included, the greatest tragedy of all would be to miss this moment and do nothing. Thank you for this opportunity.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

**STATEMENT OF THE AMERICAN DIABETES ASSOCIATION
CONCERNING PRESIDENT CLINTON'S PROPOSAL FOR
COMPREHENSIVE HEALTH CARE REFORM**

by

James R. Gavin, III, MD, PhD
President
American Diabetes Association

before the

Health Subcommittee
House Ways and Means Committee

Monday, November 15, 1993

Good morning. My name is Dr. James Gavin. I am the Senior Scientific Officer for the Howard Hughes Medical Institute and President of the American Diabetes Association. The American Diabetes Association is the nation's largest voluntary health association representing the health care and medical research interests of more than 13 million people with diabetes and the health care professionals who serve them. The association comprises 53 state affiliates and 800 local chapters. Our mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

I appreciate this opportunity to present to you our views on President Clinton's health care reform proposal. The American Diabetes Association strongly supports the Clinton Administration's efforts to reform the U.S. health care system. We especially endorse the general theme of prevention. The President's proposal addresses the general areas of concern outlined in the association's *Statement of Principles on Health Care Reform*:

Principle I: Ensure universal access to quality diabetes treatment.

Principle II: Prohibit pre-existing condition exclusions.

Principle III: Provide coverage for prescription drugs and insulin, diabetes-related supplies equipment and education.

Principle IV: Mandate community rating.

For our purposes, the timing of these hearings could not be better. We are pleased that recent clinical trials and research studies have clearly shown that diabetes complications can be prevented or delayed by proper treatment. Thus, we feel that it is our obligation to ensure that the basic benefits package is defined to include access to appropriate diabetes treatment and management.

Let me address the specific areas of concern which the American Diabetes Association believes need to be clarified in the President's proposal.

1. The Clinton proposal includes coverage for durable medical equipment such as blood glucose meters. However, it is not clear that the necessary supplies -- specifically test strips and lancets -- are also included in the basic benefits package. The American Diabetes Association believes that durable medical equipment and the supplies necessary for the proper function and maintenance of the item should be included in the basic benefits package.
2. Under the "new Medicare benefits" section insulin is specifically included. Insulin must be administered by a syringe or an infusion pump. These tools

are as necessary as the insulin itself. However, it is not clear whether the President's plan includes insulin syringes, infusion pumps and tubing under the new Medicare benefits section. Furthermore, these items also need to be included in the basic benefits package. **The American Diabetes Association believes that prescription drugs and insulin, syringes, infusion pumps and tubing should be included in the basic benefits package and the new Medicare benefits section.**

3. Education, or self-management training, has been shown to be a critical component of diabetes control and maintenance. In order to improve outcomes and prevent complications, people with diabetes must learn to administer insulin and/or other medications, monitor blood glucose levels and adjust diet and exercise to maintain good health. Health education classes are cited in the President's plan, but the language indicates that health plans *"may"* offer such services. The American Diabetes Association believes that health plans should be required to include diabetes outpatient self-management training services under the basic benefits package and under the Medicare benefits package. In July, the state of New York adopted legislation requiring the inclusion of diabetes-related supplies, equipment and education in all policies written in the state. **The American Diabetes Association believes that such an important benefit should be included in any comprehensive health care reform package.**
4. In order to achieve adequate levels of self-management, people with diabetes require the services of a variety of health professionals in the management of their disease. The President's plan defines health professionals and health professional services for inclusion as a covered benefit, however, it is unclear whether these definitions include the services of dietitians and nurses. **The American Diabetes Association believes that the services of dietitians and nurses are an integral part of the diabetes health care team and should be included in the basic benefits package.**

Diabetes costs our nation more than \$91 billion annually in direct and indirect costs. Despite the major public health impact of diabetes, the United States' healthcare system fails to provide necessary and effective preventive services for people with diabetes which can reduce long-term costs associated with complications such as blindness, kidney failure and amputation and prevent disease. The results of the Diabetes Control and Complications Trial (DCCT), a multi-year study sponsored by the National Institutes of Health, shows in a definitive way that diabetes complications can be prevented or delayed for most people with type I (or insulin-dependent) diabetes. These findings are important for all people with diabetes, but will prove ineffective if their access to these services is denied.

Finally, the DCCT is a perfect example of the critical importance of federal funding for research. With the dramatic advances made in the field of diabetes research in recent months, I would be remiss in my duties as a physician and researcher if I did not acknowledge the contributions of the federal government in achieving these results.

Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

Mr. McDERMOTT. Ms. Aukett.

STATEMENT OF LINDA KING AUKETT, PRESIDENT, UNITED OSTOMY ASSOCIATION, ON BEHALF OF THE DIGESTIVE DISEASE NATIONAL COALITION

Ms. AUKETT. Thank you.

Congressman McDermott, Chairman Stark, and members of the subcommittee, thank you for the opportunity to present the views of the Digestive Disease National Coalition, or the DDNC, on health care reform.

The DDNC is composed of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases, such as inflammatory bowel disease, a varieties of cancers, ulcers and other very complex chronic diseases.

The six principles of the plan outlined by the Clinton administration to improve our Nation's health care system are goals embraced by each of the organizations of our coalition. Among those principles that are most central to individuals suffering from digestive disease is universal health insurance coverage that can never be taken away.

Twenty-two years ago, my ulcerative colitis led to ileostomy surgery that has left me with an ostomy appliance attached to my abdomen to collect my body's waste. Even though I, unlike many patients with chronic digestive diseases, have not had a recurrence of inflammatory bowel disease in that 22 years, I and hundreds of thousands of others suffering from digestive problems have been discriminated against by health insurers because of preexisting conditions.

Most people with severe digestive problems cannot obtain health insurance because we are considered a bad risk and are undesirable to those offering medical benefits. Yet even after 22 years of average medical experience, I have the privilege of paying exorbitant fees for questionable health insurance coverage.

The administration's proposal, a system in which every American would be covered and would not be discriminated against, is a dream come true for countless citizens of this Nation like myself. There are, however, some components of the health care reform proposal on which persons with digestive diseases would like to comment specifically.

In the area of prevention benefits, we are concerned with colorectal cancer, which is the second leading cause of cancer death in the United States. With 155,000 new cases each year, the death rates from a diagnosis of colorectal cancer approaches 60 percent. This disease accounts for over one-half of the 80,000 ostomy operations performed each year. Anyone can get colorectal cancer, as the members of the voluntary association I head can attest.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients and the administration's reform proposal does not include coverage for periodic screening as a benefit in the preventive health benefits section.

The DDNC strongly urges your subcommittee to include coverage for periodic screening for colorectal cancer as a preventive benefit and to make it reimbursable under Medicare in the package devel-

oped by Congress during its consideration of health care reform legislation.

Guidelines for screening adopted by the DDNC and by the American Cancer Society are listed in a 2-page document that I will provide for you and I hope you will agree to include it in the hearing record. It is our sincere hope that your subcommittee will include coverage of benefits consistent with these agreed upon guidelines. To do less would deprive those who run the risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

We have a concern as well with regard to access to specialists. Many persons suffering digestive diseases have very complex or rare problems that require the attention of a qualified specialist or a team. Many times the person with a chronic digestive disorder searches for years for a specialist who can manage their complicated problems. Even among gastroenterologists, for example, there are those who specialize in the management of patients with specific diseases. Freedom of choice must mean the right of a patient to select his or her own physician, including both primary care physician and specialist.

The proposed health care system comes up short in two specific areas relating to the complex and unusual nature of digestive disease. First, the restrictions associated with preferred provider organizations, HMOs, and managed competition do not give a patient with chronic complicated diseases the freedom to find the right medical specialist. Instead, just the opposite is feared by members of the coalition membership organizations. The cost differential for out-of-plan or point-of-service should not be so great as to preclude this option.

Our second concern is the proposed deemphasis on the training of medical specialists. None of us would argue the need for a greater emphasis on primary care, but patients suffering complicated digestive illness would agree one should not be forsaken for the other.

Patients suffering from digestive disease are concerned that the proposed system would limit the number of qualified specialists available to treat our diseases and this deemphasis on specialist training would lead to a virtual drying up of medical and scientific expertise.

Our final concern is, while the DDNC generally supports the proposed benefits outlined for ostomy supplies and home care services, such as parenteral and enteral nutrition, we would recommend that patients be ensured a choice of suppliers and not be unduly constrained by such programs as sole source contracts.

In the managed care system, the ability to do clinical research also needs to be preserved. This may necessitate the ability of a hospital to negotiate special reduced fees for examinations performed as part of research protocol.

I thank you for the opportunity to present our views and would welcome the opportunity to respond to questions.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

**TESTIMONY OF LINDA KING AUKETT
PRESIDENT, UNITED OSTOMY ASSOCIATION, ON BEHALF OF THE
DIGESTIVE DISEASE NATIONAL COALITION**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Digestive Disease National Coalition (DDNC) on health care reform.

The DDNC is comprised of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases, such as inflammatory bowel disease, a variety of cancers, ulcers, and other complicated, chronic diseases.

Mr. Chairman, the six principles of the plan outlined by the Clinton Administration to improve our nation's health care system are goals embraced by each of the organizations of our Coalition. Among those principles that are most central to individuals suffering from digestive disease is universal health insurance coverage that can never be taken away.

Twenty-two years ago my ulcerative colitis led to an ileostomy which has left me with an ostomy appliance attached to my abdomen to collect my body's waste. Even though I, unlike many patients with chronic digestive diseases, have not had a reoccurrence of inflammatory bowel disease for twenty-two years, I and hundreds of thousands of others suffering digestive problems have been discriminated against by health insurers because of our "preexisting conditions". Most people with severe digestive problems can not obtain health insurance because we are considered a bad risk, and undesirable by those offering medical benefits. Even after twenty-two years of average medical experience, I have the "privilege" of paying exorbitant fees for questionable health insurance coverage. The Administration proposing a system in which every American would be covered, and not be discriminated against, is a dream come true for countless citizens of this nation like me.

Mr. Chairman, there are some components of the health care reform proposal on which persons with digestive diseases would like to comment specifically.

Prevention Benefits and Colorectal Cancer Screening

Colorectal Cancer is the second leading cause of cancer death in the United States with 155,000 new cases each year. The death rate from a diagnosis of colorectal cancer approaches 60%. Colorectal cancer accounts for over half (1/2) of the 80,000 ostomy operations performed each year. Anyone can get colorectal cancer, as the members of the voluntary association I head can attest.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients, and the Administration's reform proposal does not include coverage for periodic screening for colorectal cancer as a benefit in the preventive health benefits section.

The Digestive Disease National Coalition strongly urges your subcommittee to include coverage for periodic screening for colorectal cancer as a preventive benefit, and reimbursable under Medicare in the package developed by Congress during its consideration of health care reform legislation.

Guidelines for screening adopted by the DDNC and the American Cancer Society are listed in a two page document that I will give you, and I hope you will agree to include in the hearing record. It is our sincere hope that your subcommittee will include coverage of benefits consistent with the agreed upon guidelines that are listed in this document. To do less would deprive those who run the risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

Mr. Chairman, colon and rectal cancer is a serious disease that needs to be included in the preventive screening benefits portion of any standard health benefits package, and the Administration's proposal needs to be amended to address America's #2 cancer killer.

Access to Specialists

Many persons suffering digestive diseases have very complex or rare problems that require the attention of a qualified specialist or a team of qualified specialists. Many times, a person with a chronic digestive disorder searches for years for a specialist who can manage their complicated problems and offer the most comprehensive care available. Even among gastroenterologists, there are those that specialize in the management of patients with specific diseases. Freedom of choice must mean the right of the patient to select his or her own doctor, including both primary care physician and specialist.

The proposed health care system comes up short in two specific areas relating to the complex or unusual nature of digestive diseases. First, the restrictions associated with preferred provider organizations, HMOs and managed competition do not give a patient with a complicated, chronic digestive disease the freedom to find the right medical specialist to manage their disease. Instead, just the opposite is feared by those suffering digestive diseases. The cost differential for "out of plan" or "point of service" should not be so great as to preclude this option.

Our second concern, Mr. Chairman, is the proposed de-emphasis on the training of medical specialists. None of us would argue the need for a greater emphasis on primary care, but patients suffering complicated digestive diseases would agree that one should not be forsaken for the other. Patients suffering from digestive diseases are concerned that the proposed system would limit the number of qualified specialists to treat our complicated diseases, and that the de-emphasis on specialist training would lead to a virtual drying up of medical and scientific expertise in terms of developing more sophisticated diagnosis and treatment of severe digestive problems.

Ostomy Supplies & Home Care

The DDNC generally supports the proposed benefits outlined for ostomy supplies and home care services such as parenteral and enteral nutrition. We would recommend that patients be given a choice of suppliers and not be unduly constrained by sole source suppliers.

Clinical Research

In the managed care system, the ability to do clinical research needs to be preserved. This necessitates the ability of the hospitals to negotiate special reduced fees for examinations performed as part of research protocol.

Mr. Chairman, again, thank you for the opportunity to present our views.

Mr. McDERMOTT. Mr. Bias.

**STATEMENT OF VAL D. BIAS, CHAIR OF THE BOARD,
NATIONAL HEMOPHILIA FOUNDATION AND ASSOCIATE
EXECUTIVE DIRECTOR, BERKELEY/ALBANY YMCA**

Mr. BIAS. Thank you, Congressman McDermott and members of the subcommittee.

My name is Val Bias. I am here today as chair of the Board of the National Hemophilia Foundation. I was born with severe hemophilia and about 10 years ago I acquired HIV through the use of blood products. A little over a year ago, I lost my wife Katie to AIDS.

Hemophilia is a genetic condition which impairs the ability of the blood to clot effectively. Since the 1970s, development of clotting factor concentrates, made from blood, and the introduction of comprehensive care have allowed most individuals with hemophilia to manage their bleeding episodes at home eliminating the need for frequent and costly hospitalizations.

During the early 1980s, over half of the Nation's hemophilia population contracted HIV through contaminated blood products. In its total devastation to a specific population, this is the worst medically induced tragedy in history. The foundation requests that the following components be incorporated into the health care reform plan being developed by the Congress: direct access to highly specialized providers and comprehensive care provided through the regional network of hemophilia treatment centers; outpatient drug coverage; and coverage for preventive services such as home care and patient education.

Based on our initial review of President Clinton's Health Security Act, NHF was pleased to see the designation of hemophilia treatment centers as essential community providers. The administration's package also includes coverage of clotting factors.

The impact of HIV on the Nation's hemophilia population has been devastating. Significant emotional and financial losses are compounded by the fact that few individuals with hemophilia have been able to purchase significant life insurance or obtain adequate health care coverage to protect themselves and their families.

Treatment costs for the majority of the population with severe hemophilia can reach \$100,000 for clotting factors plus another \$30,000 for HIV/AIDS drugs. For this reason, the National Hemophilia Foundation is seeking immediate health care coverage under the Medicare program for the hemophilia population.

During the transition to full implementation of health care reform, individuals with hemophilia would be made eligible for Medicare benefits until provisions are in place for each State that could adequately take the place of the Medicare program.

Reforms to the health care system include universal coverage that may not take effect for 5 years. Without changes to the existing discriminatory insurance policies, that is, lifetime maximums, the hemophilia community will continue to face a crisis situation.

Thanks to the leadership of this committee, Medicare benefits for patients with hemophilia have greatly improved. Utilizing the Medicare program for this population during a transition to a broad-based reform is in line with the intent and the spirit of the Health

Security Act as well as the mediplan legislation introduced by the subcommittee Chairman.

We ask that consideration also be given to an additional request. NHF recommends that through the Social Security system cash assistance benefits similar to the disability benefits be provided to people with hemophilia who are HIV positive and for individuals who are survivors of those who have died of AIDS.

NHF also requests the establishment of self-financing trust funds supported by a surcharge on all human and animal blood and plasma collected for human use to provide these eligible individuals with a lump sum payment to meet urgent financial living needs.

The Federal Government has frequently assisted people with special needs, especially when private sector safety nets are unavailable. Most of the affected individuals have worked and contributed to the Social Security system. As they have paid money to the government for this purpose, they are entitled to its benefits. The request is only that the benefits be accelerated in time.

Thank you and I would be happy to answer any questions you might have.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

STATEMENT OF THE
THE NATIONAL HEMOPHILIA FOUNDATION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATE HOUSE OF REPRESENTATIVES

PRESENTED BY
VAL D. BIAS

NOVEMBER 15, 1993

Mr. Chairman and Members of the Subcommittee, my name is Val Bias. I am the Associate Executive Director of the Berkeley/Albany YMCA. I am here today as the Chair of the Board of the National Hemophilia Foundation. The National Hemophilia Foundation (NHF) is a voluntary health agency working to improve the health and welfare of the 20,000 persons with hemophilia, von Willebrand disease, and other clotting deficiencies in the U.S.

I was born with hemophilia and about 10 years ago I acquired AIDS through the use of blood products. A little over a year ago I lost my wife Katie to AIDS.

Background Information on Hemophilia and the Impact of HIV/AIDS

Hemophilia is a genetic condition which impairs the ability of blood to clot effectively. If untreated, persons with hemophilia suffer internal bleeding, leading eventually to destruction of the joints and muscle tissues. Since the 1970's, the development of clotting factor concentrates, made from blood, and the introduction of comprehensive care have allowed most individuals with hemophilia to manage their bleeding episodes at home. Clotting factor eliminated the need for frequent and costly hospitalizations and ensured that even persons with severe hemophilia were able to attend school, obtain full time employment, and enjoy a greatly increased life expectancy.

During the early 1980's the nation's blood supply was contaminated by HIV-infected donors. While the blood supply was at risk in the early 1980's, over half of the nation's hemophilia population contracted HIV. Eighty percent of children and adults with severe hemophilia were infected, and more than ten percent of wives of infected men were also exposed to the virus. Many newborn babies were exposed through perinatal transmission. In its total devastation to a specific population, this is the worst medically induced tragedy in history.

The financial burden of hemophilia, and HIV, jeopardizes the future of the hemophilia community. The average cost of therapy for those with severe hemophilia is nearly \$100,000 each year. The cost of HIV/AIDS care, is estimated to be \$10,000 - 50,000 annually per patient. These staggering costs for care are far beyond the financial capacities of most people.

Necessary Benefits for Persons with Hemophilia and HIV/AIDS

During the past year, representatives of the National Hemophilia Foundation (NHF) had the opportunity to testify before you and Members of this Subcommittee as well as to meet with the President's task force on health care reform. Our message has been that chronic diseases like hemophilia require regularized medical supervision, intense and comprehensive intervention therapy, and long term preventive care to appropriately manage patients with chronic disease. For us, this means a benefits program that provides for:

- direct access to highly specialized multi-disciplinary providers and comprehensive care provided through the regional network of comprehensive hemophilia treatment centers,
- out patient drug coverage, and
- coverage for services such as home care, prevention and patient education.

NHF requests that these components be incorporated into the health care reform plan being developed by the Congress. Based on our initial review of President Clinton's Health Security Act, NHF was pleased to see the inclusion of some of our key requests and views the President's proposal as a good starting point in terms of the benefit coverage features of the plan. The Administration's plan designates the comprehensive hemophilia treatment centers as "essential community providers" with the requirement that all health plans contract with such entities. This will ensure that all individuals with hemophilia have direct access to their hemophilia treatment centers without being subject to any gatekeeper requirements. The Administration's package also includes coverage of clotting factors provided on an outpatient basis as a component of the outpatient drug coverage included in the plan's comprehensive benefit package provided to all Americans.

The combination of these two elements, together with coverage under the outpatient drug benefit for off-label and certain experimental usage of drugs, provides an excellent foundation but requires closer scrutiny and specification. Without assured coverage of these services and direct access to treatment center providers, the managed care plan aspects of the Clinton bill would likely have negative effects on the hemophilia population because historically, such plans have redlined out individuals with hemophilia from coverage or significantly limited access to necessary specialized services and drugs. Also, it is important that new technologies that offer improved blood product safety are readily accessible.

As your Committee wades through the President's plan and various proposals, it is important to specify how the hemophilia treatment centers and other specialized and needed provider networks will be sustained as essential community providers. Will health plans contracting with the treatment centers be able to limit or direct the care provided or could they postpone or deny essential treatments in an effort to hold down costs?

Further, the Administration's package does not adequately address the need for home, prevention and education services for the hemophilia population, as well as others suffering from chronic diseases. Through comprehensive treatment persons with hemophilia are educated and trained to determine when they are having a bleeding episode, or in the case of parents how to determine when their child is having a bleed; and then how to administer clotting factor in the home. This immediate attention to a bleeding joint has had an incredible preventive effect resulting in fewer crippling side effects as well as reducing the need for risky and costly surgery. In today's hemophilia community over 90% of patients receive their clotting factor at home and either self-infuse or have a family member assist them. It is essential that this cost effective, preventive care be maintained under health care reform.

Needed Coverage During the Transition to a New Health Care System

The impact of HIV on the nation's hemophilia population has been devastating. The HIV contamination of the blood supply has caused significant emotional and financial loss to this community. These losses are compounded by the fact that few individuals with hemophilia have been able to purchase sufficient life insurance or obtain adequate health care coverage to protect themselves and their families.

For this reason the National Hemophilia Foundation, in conjunction with its chapters and treatment centers, is seeking immediate health care coverage under the Medicare program for the hemophilia population and for the survivors of those who have died of AIDS during the transition or phase in to full implementation of health care reform. We suggest that the health care reform legislation provide eligibility to the Medicare program for individuals with hemophilia who can then enroll. Individuals with hemophilia would be eligible for Medicare benefits until provisions are in place in each State that could adequately take the place of the Medicare

program.

Thanks to the leadership of this Committee, Medicare benefits for patients with hemophilia have improved. Clotting factor is covered on a per unit cost basis for inpatients and is fully covered for outpatients. Using the Medicare program for patients with hemophilia during a transition to broad based reform will meet the immediate needs of the community and is in line with the intent and spirit of the Health Security Act as well as the Mediplan legislation introduced by the Subcommittee Chairman.

Most of us do not expect reforms to the health care system and a plan for universal coverage to take effect for four to five years. Without changes to existing discriminatory insurance policies, such as pre-existing condition limitations, life-time maximums or coverage ceilings and lack of portability, the hemophilia community will continue to face a crisis situation. With over 60% of the total hemophilia population HIV positive and many individuals fighting full blown AIDS, both two year waiting periods to get on the Medicare program or spending down resources to qualify for state Medicaid benefits seem inhumane. Where relatively healthy individuals may be able to get through an acute care episode without insurance by paying out of pocket, persons with chronic diseases like hemophilia and AIDS will have constant and intensive medical needs that must be provided in an immediate and appropriate manner.

Social Security Improvements Integral to Health Care Reform

As security for individuals and families is at the forefront of the debate on health care reform and is the basis of the social security system, we ask that consideration be given to broadening social security assistance for individuals with hemophilia in need. NHF recommends that the reform legislation include a provision to amend the Social Security program to provide cash assistance benefits similar to disability benefits to people with hemophilia who are HIV positive and for individuals who are survivors of those who have died of AIDS.

The hemophilia community must turn to the Federal government for assistance in the face of this catastrophe. The inability of many individuals with hemophilia to obtain health and life insurance has made it impossible for them to protect themselves and their families as would be the case for most other people. The Federal government has frequently assisted people with such special needs especially when the private sector "safety nets" are unavailable. Most of the affected individuals have worked and contributed to the Social Security system. As they have paid money to the government for this purpose, they are entitled to its benefit. The request is that the benefits be accelerated in time.

Trust Fund

The Foundation is also seeking Subcommittee consideration of establishing a self-financing trust fund supported by a surcharge on all human/animal blood and plasma collected for human use, either as whole blood, plasma or derivative products to provide eligible individuals with a lump sum cash payment to meet urgent financial living needs. We are proposing this means to financing a cash benefit to individuals in order to comply with the requirements of the Budget Control Act in funding new benefits.

The comprehensive nature of this disaster means that private sector mechanisms and resources are inadequate to meet the needs of the hemophilia population. We believe there is precedent where the government has mandated private industry to provide relief or finance benefits provided to a defined group of individuals. The rationale for this approach is that there is a shared public and private responsibility to maintain the safety of the blood supply. People with hemophilia continue to depend on our nation's blood supply and are susceptible to any future blood borne diseases that might be present. In fact the hemophilia community may again be

the early warning signal of problems for the rest of our nation's population. It is only right that the government and the entire blood industry work together to provide funds and services to assist these individuals and their families whose need is so extreme.

Mr. McDERMOTT. This panel raises one of the most difficult aspects of national health care reform, and that is the whole decision of how you deal with chronicity. Our health care system is pretty good at dealing with acute illness. One way or the other we get most of that done in a fairly reasonable way. But once we get into a chronic illness situation, we have a long-term problem.

My concern, as I listened to earlier testimony, some of which you may have heard, where people are talking about the point-of-service option in an HMO for those people who have a particular primary care physician, we were talking earlier with women's health that the gynecologist for most women is basically the primary care physician.

What is your understanding of the President's plan in terms of its applicability to your patients selecting a particular specialist as their primary care physician rather than a general practitioner who would then have to refer them on? How do you understand it? What would it cost?

Somebody raised the question of how much money somebody should have to pay to have the point-of-service option, so I am interested in your assessment of the President's plan in terms of making it available to people. And anybody can start.

Ms. MEYERS. We were very concerned about this issue because people with rare diseases usually cannot get service locally. There are some diseases, for instance, where three or four doctors in the whole country know anything about it, and one of the problems we have been seeing in recent years is that if a patient in California needs to go to the only doctor who knows the disease who happens to be at Yale, a local HMO in California would not agree to pay the doctor at Yale. So besides the cost of the transportation, you could not have surgery or any major medical procedure unless your HMO approved it in advance.

And so I think that the plan is very good in that it is going to allow people to see specialists if they are willing to pay the 20 percent—out of the 100 percent, to pay 20 percent and you would have that point-of-service option, rather than saying if you are an HMO, there is no way at all that you will be able to see somebody who is outside of the plan.

I think once you are referred by your general practitioner to a specialist, you are not going to have to get permission every time from your general practitioner. Once you have been referred, for instance, to a neurologist, you will be able to continue going back to that neurologist.

Mr. McDERMOTT. So it is your understanding that once you have established a relationship with a specialist, it would not be necessary for you to go back through your primary care physician?

Ms. MEYERS. That is the way I understand it.

Mr. McDERMOTT. Is that the general understanding of this panel; that once somebody, if they are in an HMO, they have established a relationship with a diabetic specialist or a cancer specialist dealing with ostomy care, that those people then would not have to go back through their primary care physician and the HMO? Is that your understanding; all they would have to do is pay 20 percent extra?

Mr. GREENBERG. I think it is not clear, and I think one of the problems about the President's plan is that it attempts to specify the types of plans, point-of-service, HMOs, PPOs, and fee-for-service, that will be offered.

I think it would be to my advantage, as a victim of heart disease, to have a choice among health plans, whether they be fee-for-service, as many plans who are allowed to go into that market which are certified plans, whether it be fee-for-service, point-of-service, HMOs, without regulations about whether or not one has to see a gatekeeper or not.

And one thing I would also caution, if I may, Congressman, and that is people who do have chronic diseases, and this is who your question was addressed to, will eventually have to pay more under the President's plan because we are the ones who have our own doctors. We are the ones who see our own doctors. Perhaps we have a disproportionate number of people in fee-for-service, and when those fee-for-service plans take people like ourselves, those costs will go up because we incur higher and higher costs, which will make those plans have higher and higher premiums.

This is one of the things we have to guard against, and that is to be careful of a self-selection of plans such that the fee-for-service plans wind up with the highest risk, the chronically ill individuals with the highest costs, and other plans have the more healthy individuals with the lowest costs. I would encourage you to be careful as you have your hearings on that point.

Mr. McDERMOTT. As to our being careful, how do you prevent that?

Mr. GREENBERG. The reforms must permit a greater rate for a case mix adjustment measure. Those plans which happen to have higher risk individuals must have a greater case mix adjustment measure to reflect that. If they have a large number of people with heart disease, a large number of people with AIDS, those people, those plans have to have a greater case mix adjustment.

Mr. McDERMOTT. Do you think we have sufficient evidence at this point—and this is addressed to the whole panel—to make real case mix adjustments prospectively, or does it have to be all retrospectively? In other words, if I have 10 diabetic cases in my program, how do I know—do we have the data on which to make a prospective payment to the plan saying because you have 10 diabetic patients you would be entitled to x dollars more because they will use health care services at a somewhat higher level than most other people?

It is a real problem, it seems to me, in terms of data.

Dr. GAVIN. I think, Congressman, if we look at some of the data we already have, for example with diabetes, as an example, we know, for example, that certain populations are disproportionately affected by diabetes. So that if there are plans which have a high number of the groups that are disproportionately affected, that we should anticipate there is going to be a greater need in those settings for the kind of standards of care for diabetes that generate appropriate outcomes. So we could make some determinations about a case mix adjustment in those plans.

We know that people with diabetes in order to avoid eye complications are going to have to have access to eye specialists. That

is not an add-on, that is not something that a gatekeeper needs to be sensitized to, that is a standard of care for people with diabetes. If they proceed to the point where their kidney function deteriorates to a certain level, it is not, that is not something about which a gatekeeper who is a knowledgeable gatekeeper would need to be sensitized. That is part of the standard of care for these persons.

So I think there is some data already that would give us some guidance about how we can make those kinds of prospective judgments.

Dr. MUNZER. We believe in the American Lung Association and the American Thoracic Society that for patients with chronic obstructive pulmonary disease, emphysema, or chronic bronchitis, care by specialists can be much more cost effective than care by generalists. There are tremendous complexities that arise in a patient who is beginning to have a low oxygen level, is beginning to retain carbon dioxide and not able to excrete it, and it takes a specialist who sees these patients day in and day out to care for them properly.

By the same token, many pulmonary specialists—and I am sure the same is true for many diabetes specialists—are also good primary care physicians. So, for example, when I have a patient with emphysema who develops symptoms of a peptic ulcer, I do not automatically refer them to a gastroenterologist; or if they develop hypertension, I am perfectly capable of taking care of that.

So I think there needs to be a lot of flexibility that is really tailored to the individual patient.

Mr. McDERMOTT. Go ahead.

Ms. AUKETT. I would recall the testimony by Mr. Stoddard on an earlier panel with regard to the ability of physicians who are specializing in certain areas to keep up with the literature and with current understanding as well, and would bring to your attention as well the doctor-patient relationship and the role that it plays in patient compliance with protocols. This is particularly pertinent to those who have a chronic situation where there is not only a medication schedule but life-style considerations as well; diet and things of that nature.

The patient-doctor relationship is so critical in encouraging the patient to maintain that routine and that protocol and to comply with it, that I think we cannot overlook the fact that access to the right physician, given a half dozen different physicians who may all have the same qualifications and the same expertise clinically, the patient-doctor relationship may click in only 2 or 3 of those matches.

Mr. McDERMOTT. Do any of your organizations have data about people's experience in managed care situations? Positive or negative. Has anybody collected any data?

Mr. BIAS. I don't think we have collected any data, but our experience, from stories I have heard as I have been traveling the country talking to many families with hemophilia, is that it does not meet their needs; especially when there is a change in treatment regimen—such as an increase in clotting usage. For patients with hemophilia, the cost of factor can range from 25 cents a unit to \$1.18 a unit, and the average person might take 2,000 or 3,000 units per injection, and that could happen weekly or daily in some

cases and that is when it gets interesting. Patients get kicked back to the gatekeeper because there is such a change in the amount of product or the amount of services being used. Data does need to be collected on managed care systems.

Dr. MUNZER. The present health care system or nonsystem really does not allow for the collection of good data and that is another thing that I think we should look to in health care reform.

Mr. McDERMOTT. Let me ask one specific question. Ms. Aukett, you raised the point that colorectal cancer was not included as a screening. Give me an explanation, if you can think of one, why they left that off? They put in some of the women's health things, which I thought was good, periodic screening for mammography and so forth, why did they leave colorectal cancer out?

Ms. AUKETT. It is very difficult to understand, especially since DDNC has for several years been coming to Congress and asking for this kind of coverage under Medicare. Certainly, the information that we have provided has been available for years.

One of the difficulties that we face, that particularly the members of my association face because of the nature of our situation, I can't call it a problem because it is not a problem to me, people do not like to talk about digestive problems. They particularly do not like to talk about things having to do with the colon and rectum, and that may have some bearing on an answer to your question. I can't say for sure.

Mr. McDERMOTT. I guess the hope of this committee is that as we evolve this plan and we try to tailor it to the needs of various groups, that you will continue to monitor what is happening and give us your input. How many million people do we have represented up here in front of us.

Heart disease. How many would you say?

Mr. GREENBERG. Well, of course, everyone is a candidate for heart disease in this country, but I think the number of individuals with heart disease is, I would say—well, I could say they account for 930,000 deaths each year, both for heart disease and stroke.

Mr. McDERMOTT. Ms. Meyers, how many do you represent?

Ms. MEYERS. It is 20 million Americans; about 5,000 rare disorders, some think—

Mr. McDERMOTT. Twenty million. That is scleroderma and all the various connective tissue diseases and all sorts of things?

Ms. MEYERS. Right. And of special interest to you, I know of your interest in psychiatric illnesses, there is a real problem with the Clinton plan not addressing psychiatric illnesses. Not just emotional problems but illnesses on par with other illnesses: Schizophrenia, Tourette's syndrome, autism will be reimbursed at 50 percent instead of 80 percent. There is something very wrong with that concept.

Mr. McDERMOTT. Is that part of your 20 million, the mental illnesses?

Ms. MEYERS. Yes, mental illness is also, as long as they affect—each one, to be rare, has to affect fewer than 200,000 Americans.

Mr. McDERMOTT. How about lung disease?

Dr. MUNZER. About 14 million patients with chronic bronchitis and emphysema, plus about 12 million patients with asthma and then assorted other disorders. More than 26 million altogether.

Mr. McDERMOTT. Why is asthma on the increase among kids?

Dr. MUNZER. The most—the best explanation that we have at the present time is that it is a change in the environment, increasing levels of air pollution, particularly in the inner cities, and also poor access to health care, particularly among the poor. It is African American children, poor children who have the highest increase in the incidence of asthma. So this is another major issue in health care reform.

Mr. McDERMOTT. Dr. Gavin, the number again you gave for diabetics?

Dr. GAVIN. For diabetes, we are talking over 13 million; those are the people actively affected. An additional 20 or 25 million people who are in a state that we would consider prediabetic, at high risk, for whom the issue of prevention is absolutely critical, because this is one of those areas where health education, changing lifestyles can make all the difference in the world in preventing them from getting to that next step.

Ms. AUKETT. I can speak in terms of numbers only for the United Ostomy Association, we estimate about three-quarters of a million people in the United States and an additional 75,000 to 80,000 surgeries being performed every year.

Mr. BIAS. Hemophilia numbers are very small in comparison to many other diseases. The difference is, by the funding that we receive, that we have pretty much been able to provide them with a life-style and be able to be productive members of society, but about 20,000.

Mr. GREENBERG. Mr. Chairman, if I might, my colleague here has suggested that—

Mr. McDERMOTT. Use the microphone so we get it all.

Mr. GREENBERG. Mr. Chairman, I wanted to be a little clearer on your question. I said 930,000 Americans died from heart and stroke each year. That was correct. But my colleague here says that more than 70 million Americans suffer some form of cardiovascular disease today.

Mr. McDERMOTT. That is treated by a specialist? How many of those 70 million would you say get to a specialist?

Mr. GREENBERG. Maybe I should ask my colleague again? I would not know, sir, I am sorry.

Mr. McDERMOTT. Well, we are looking at at least more than 50 million people represented by this panel, and it is obvious that the question of chronic disease is one of the most difficult, thorny ones with which to deal in the whole of health care reform and we appreciate your coming today and we will wait your further observations as we move down the line. Thank you.

Mr. McDERMOTT. The next panel, Dr. Joel Saper, who is the director of the Michigan Head-Pain and Neurological Institute from Ann Arbor, Mich.; Dr. James Walsh, the chairman for the committee on government affairs and public policy of the American Sleep Disorders Association; Peter Thomas, the legislative director for the Amputee Coalition of America; J.B. Cordaro, president of the Council for Responsible Nutrition; Ronald Burd, the president of the Devereux Foundation; and Mary Ann Beall, board member of the National Alliance for the Mentally Ill.

As soon as we get your name tags in front of you, so I know who is who, I will start. Dr. Saper.

STATEMENT OF JOEL R. SAPER M.D., FOUNDER AND DIRECTOR, MICHIGAN HEAD-PAIN AND NEUROLOGICAL INSTITUTE, ON BEHALF OF THE AMERICAN PAIN SOCIETY, THE AMERICAN ACADEMY OF PAIN MEDICINE, AND THE AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

Dr. SAPER. Congressman McDermott, I am Dr. Joel Saper, clinical professor of neurology and founder of the Michigan Head-Pain and Neurological Institute in Ann Arbor. For 23 years, I have devoted my medical career to evaluating and treating desperately painful patients referred from throughout the world. I appear today on behalf of the Nation's credentialed pain experts, along with millions of painful patients we treat.

I want to talk about pain; intractable, disabling pain, another, if you will, of the chronic complex illnesses that you just discussed. Intractable pain is a serious but largely ignored public health problem. Between 50 and 80 million Americans are partially or totally disabled by pain at some time in their lives and \$24 billion is spent on the treatment of back pain alone annually. Pain is an invisible disability. It severely impacts the quality of life and function forcing desperate patients to seek relief at any cost to their health and pocketbook. Many are driven to addiction and despair, some to suicide.

Congressman McDermott, 10 of Dr. Kevorkian's first 15 patients reported pain as a principle reason for their suicidal request.

Intractable pain sometimes is an illness in itself, as in migraine or back pain, or can arise from cancer, diabetes, trauma and hundreds of other ailments. It can be genetic.

Patients with severe pain cannot wait months, weeks or even days for treatment, and primary care physicians eager to help but without sophisticated resources or training resort to narcotics and temporizing solutions which frequently make the problem more complex and costly to treat.

The President's plan does not adequately address the treatment realities of patients with intractable pain which are frequently not available in tightly managed settings. Advanced clinical skills are necessary, sometimes from teams of physicians, nurses, psychologists and others, to control pain, addiction, depression, and functional impairment which all must be addressed simultaneously.

This is not primary care. Such illnesses require special consideration in a reform plan, however, effective early control can bring immense human and cost benefits.

The President's plan promises primary prevention to prevent illness, but illness does happen. The plan ignores secondary prevention—aggressively managing complex illness to prevent costly complications or deterioration from mismanagement or neglect, restoring function before irreversible disability and regression occur.

In my field, secondary prevention means preventing addiction, disability, depression, suicide, needless surgery, redundant testing or unnecessary hospitalizations, which can be reduced by effective early care.

Congressman McDermott, we see patients who desperately require care but whose gatekeepers have become jailkeepers, some with financial incentives to deny or delay referral. We see patients who have been down an assembly line of unlimited uncoordinated services and procedures in desperate search of relief and referred to experts only after tens of thousands of dollars of failed services have been provided.

A complex illness has become more difficult and costly to treat. In my center, 70 percent of first time patients are dependent upon pain killers when they first arrive and hundreds each year have had needless and complicating surgery. Here are three brief examples:

A 35-year-old Canadian man who in 5 years had four destructive surgical procedures for daily head pain was finally referred, still painful and toxic from 57 Tylenol and codeine per day; a 43-year-old woman with an initially simple back injury causing pain underwent seven operations and 20 years of pain and drug dependency and became fully functional and returned to full time teaching following appropriate treatment; and a 45-year-old California man suffering from disabling head pain after brain surgery was denied referral by his plan even though his own specialists were not able to help him and recommended the referral.

Congressman, NIH, through the decade of the brain program and the House Appropriations Committee have both identified pain as an important and costly public health problem in need of greater research funds with more effective treatment. AHCPH brought attention to the inadequacy of cancer pain and acute pain treatment in the United States. The process has begun, please help us sustain it.

Because of the limits of time, we will submit specific recommendations that address these issues and I will close by asserting only that innovative and necessary clinical advancement must not be derailed in the name of cost control and reform. Well spent dollars now will save much more in time.

Mr. McDERMOTT. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF JOEL R. SAPER, M.D.

on behalf of

AMERICAN PAIN SOCIETY
 AMERICAN ACADEMY OF PAIN MEDICINE
 AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

Mr. Chairman and members of the Subcommittee, I am Dr. Joel Saper, founder and director of the Michigan Head-Pain and Neurological Institute in Ann Arbor, Michigan. I am pleased to appear today on behalf of the American Pain Society, the American Academy of Pain Medicine, and the American Association for the Study of Headache. These three organizations represent clinicians and researchers who treat the nation's intractable pain patients, including those with cancer, migraine, back pain, and many other conditions. Personally, I have devoted almost my entire 23 year career in medicine to teaching, researching, and writing on pain, and treating thousands upon thousands of severely painful patients referred to my center from around the world.

Intractable pain is a serious public health problem in the United States, yet it is virtually unrecognized. It is an invisible disability affecting major segments of our society. Fifty million Americans are partially or totally disabled by pain, and 45% of all Americans will seek care for persistent pain at some point in their lives. While headache and low back pain are the most prevalent forms of intractable and persistent pain, pain accompanies a wide range of clinical conditions including cancer, diabetes and arthritis. Pain imposes enormous costs on the patient, the economy, and the health care system. Intractable pain impacts dramatically on the quality of an individual's life and the ability to function. Productivity losses due to pain are estimated at \$85-90 billion per year. 150 million workdays are lost annually to head pain alone. Of the estimated 400,000 back surgeries performed annually, only a fraction appear necessary in pursuit of pain control. 22% of work-related injuries involve persisting pain. Even children lose one million school days annually due to pain.

The focus of today's hearing is on health benefits and the President's reform proposal. We have reviewed the benefit package, and consider it to be a generous one, with one caveat: it relies too heavily on categorical distinctions between hospitals, doctors, and other providers. It does not effectively address high cost, complex, intractable illness which requires advanced levels of care and time, often by comprehensive, interdisciplinary teams of professionals or advanced treatment techniques by specially trained practitioners.

Our much larger concern with the Clinton reform proposal is whether the benefit package it promises can be delivered? Or, in the cases of the patients we serve, will it prove to be an empty promise?

The President's proposal does not guarantee delivery of the benefit package, because it does not guarantee the patient's access to necessary and appropriate care for intractable pain and similar illnesses. Certain illnesses are not effectively treated in tightly controlled systems emphasizing primary care. These conditions are frequently misdiagnosed or undiagnosed. Patients are frequently mismanaged or untreated. "Gatekeepers" can become jail keepers, impeding rather than facilitating early intervention. These cases stand out, they are widespread, and they require special consideration in any health care reform legislation.

Intractable pain, like other complex illnesses, can be effectively treated in most cases, but it requires early intervention by appropriately trained specialists in appropriate settings. The Clinton plan focuses on primary preventive care, but illnesses and injury will nonetheless occur. The plan ignores the important role of special outpatient centers of care and secondary prevention concepts - preventing the avoidable complications or deterioration, and restoring health and function where possible, by aggressive, comprehensive, outpatient advanced care interventions. For pain, secondary prevention includes preventing addiction, depression, disability, needless surgery, and repetitive testing, among others.

Those of us who treat intractable pain see the dark side of both over- managed and under-managed care.

We evaluate and treat patients who are in desperate search of relief and require intense and experienced intervention, but who have been needlessly delayed or denied access to such care by primary care "gatekeepers" who either do not understand the problem, are insensitive to it, or who flatly refuse to refer such a patient. Increasingly, we see insurance administrators who reject the "gatekeepers" referral approval, for economic reasons alone. As with justice, in the case of intractable pain, treatment delayed is treatment denied, and treatment delayed leads to more costly interventions later on and avoidable suffering and human travail. Patients often desperately seek our care, approved by their systems or not. Quality of life can be stabilized or restored. Function can be improved, and yet payment for such services is routinely denied by managed care organizations because we were not preauthorized or we are not part of the right "network." And when managed care systems do approve payment, they want to pay doctors for usual and customary care, not interdisciplinary teams for advanced care and management of complex cases.

Recently, a 44-year old man came to our center from California. He suffered from severe, intractable head pain following the successful removal of a brain tumor, but his managed care organization had denied repeated referral requests by his treating physicians. He funded his own care at our center, was successfully treated and returned to work, but had to wage legal warfare for his services to be covered, despite having been unsuccessfully treated over and again by specialists in his own health care system.

We also see patients with fee-for-service insurance who have bounced down an assembly line of procedures and practitioners in a desperate search for relief. They come to us with thick files and huge health care costs already incurred. They have had multiple diagnostic tests performed, and been subjected to needless and often counter-productive surgery. In my center, over 70% of first-time patients are addicted to pain medications, and have been addicted for years, prior to referral.

The cost of mismanaging complex cases is tragic in human terms, and excessive in financial terms. Patients frequently become drug addicted and disabled, as much from their treatment, as from the underlying cause. As desperate as is the patient, so too is the primary care physician who in an effort to relieve the suffering, prescribes narcotic or other interventions which inadvertently contribute to and confound the problem.

Let me share several examples with you:

- a 35-year old man from Canada, who in five years underwent four destructive surgical procedures on his face for relief of pain, and who was referred five years after his pain began. By then, he was taking 57 Tylenol with codeine per day.
- A 25-year old Indiana woman who came to use self-injecting morphine every four hours through a permanently inserted IV line for daily migraine, and who is now undergoing rehabilitation and learning to return to normal function.
- A 44-year old Michigan woman suffering from head and neck pain following a motor vehicle accident, who spent at least \$40,000 on health care services, and who was referred only after years of addiction to increasing amounts of narcotics.
- A 43-year old woman with a simple back sprain who underwent seven laminectomies and 20 years of pain and drug dependence, and who after four weeks of effective treatment became fully functional and is now returned to full-time teaching.
- A 36-year old woman with 32 surgical procedures for what turned out to be a simple back sprain was disabled for 14 years, house-bound, and required an attendant 24 hours a day, was depressed, addicted to morphine (five times the normal dose), and who after five weeks of treatment became fully active, resumed her life as wife and mother, no longer requiring attendant services.
- Perhaps most dramatic of all, in my own state of Michigan, 10 of Dr. Kevorkian's first 15 induced suicides reported intractable pain as a primary justification for their suicidal requests.

These patients could have been helped, but they suffered for years the needless agony, personal consequences, and costs of delayed, ineffective treatment and the complications of

inappropriate intervention. Public policy must distinguish between those cases of complex, chronic illnesses, such as substance abuse, intractable pain, and mental health problems that require time-critical, advanced levels of care, and those more routine, standard medical conditions which are appropriately managed on a primary care level. It must also distinguish between specialists who treat patients by personal intervention and clinical skills, and those specialists who deliver high-tech, procedural diagnostic and treatment services.

Mr. Chairman, if the Federal government wants to ensure the delivery of health benefits through the regulation of health plans, it is mandatory that it address this problem. The organizations I represent urge your consideration of the following principles in dealing with intractable pain and similar illnesses:

- Fee-for-service and point of service options should be real - not subject to waiver by states, alliances or plans, or to unreasonably high cost sharing.
- Qualified health plans, whether fee-for-service or managed care, must guarantee patient access to, and actually deliver, either directly or through relationships with appropriate referral centers, the specialty care required.
- Gatekeepers in qualified health plans must be properly trained for the clinical judgements they are asked to make, and accountable for those clinical judgements.
- Referral arrangements for intractable pain and similar complex illness must be targeted to properly trained professionals, academic centers, and "centers of excellence" at a time when cost effective interventions and secondary prevention are most likely to succeed. While the Clinton plan briefly acknowledges "centers of excellence," the concept must be developed responsibly and in greater detail. Advanced, credentialed levels of care offer human and cost advantages for patients with complex, high cost, intractable illness. The Clinton plan also includes important provisions for academic health centers, but the treatment dollars are directed at inpatient teaching hospitals. Criteria are available to identify high quality, credentialed ambulatory (outpatient) centers that have comparable or even greater expertise in particular illnesses. These centers can often provide that expertise at a far lower cost, and with the aim of maintaining patients out of hospital settings through aggressive and comprehensive outpatient strategies and intervention.
- Finally, qualified health plans should be required to use provider fee schedules that recognize the scope and intensity of services delivered by advanced care systems and practitioners, and multi-disciplinary teams to patients who fail to respond to customary and usual care.

The science and clinical skills related to the effective control of cancer pain and other forms of acute and intractable pain are emerging. They are not yet widely practiced or available throughout the nation. This, coupled with the unfortunate prejudice often heaped upon individuals whose illnesses in their time are poorly understood, or cannot at that time in the history of medicine be "proven," makes these patients and the credentialed professionals and yet developing systems of care particularly vulnerable to the shifting sands of health care reform.

Pursuit of excellence and advanced, compassionate skills in medicine must not be lost in the process of reform. To the contrary, these represent the goals of clinical science. It is not scholarly innovation and comprehensive, advanced care for special patients that are too expensive. It is too costly to discard them! It is pioneering experts in these new fields who will do the teaching, write the books, and perform the necessary clinical research that are required for advancement and training of primary care physicians. Please do not allow this important and humane movement to be derailed in the name of progress.

POSITION STATEMENT
on
HEALTH CARE REFORM

The American Pain Society, the American Academy of Pain Medicine and the American Association for the Study of Headache strongly support universal health coverage for all Americans. At the same time, these organizations urge policymakers to recognize that coverage and benefits must also guarantee access to appropriate care. Any Federal legislation which relies on managed competition or managed care, must address the special needs of special patients - patients whose illnesses fall outside the realm of usual and customary care.

Certain illnesses, and complex or advanced cases of many others, are not effectively treated in tightly controlled systems emphasizing primary care services. These conditions are frequently misdiagnosed - or undiagnosed. Patients are frequently mistreated - or untreated. "Gatekeepers" impede rather than facilitate appropriate early intervention. These cases stand out. They are not routine. When they are widespread, chronic, and high cost, they require special consideration in any new Federal legislation.

Certain of these illnesses, including intractable pain are also literally intolerable to the patient. They impact so dramatically on the quality of an individual's life and the ability to function as to prompt desperate searches for relief in and out of a patient's primary health network, and in and out of proven treatment modalities.

Reform must deal fairly and effectively with these special needs of special patients. The undersigned strongly urge inclusion of the following protections for patients afflicted with intractable pain, including cancer pain and acute pain, and similar conditions:

- I. EVERY CONSUMER SHOULD HAVE A FEE-FOR-SERVICE AND POINT OF SERVICE OPTION AT THE TIME OF HEALTH PLAN ENROLLMENT. THIS OPTION SHOULD BE REAL - NOT SUBJECT TO WAIVER BY STATES, ALLIANCES OR PLANS, OR SUBJECT TO INORDINATELY HIGH COST SHARING REQUIREMENTS.
- II. QUALIFIED HEALTH PLANS MUST GUARANTEE PATIENT ACCESS TO, AND ACTUALLY DELIVER APPROPRIATE SPECIALTY CARE FOR INTRACTABLE PAIN AND SIMILAR ILLNESSES.
- III. GATEKEEPERS EMPLOYED IN QUALIFIED HEALTH PLANS MUST:
 - Be properly trained for the clinical judgements they are asked to make, e.g. where prior authorization is required for specialty referral or treatment;
 - Not have financial incentives to undertreat or under-refer;
 - Perform a contemporaneous evaluation of the patient before overriding another physician's clinical judgement; and
 - Be accountable for the clinical judgements made in their capacity as gatekeepers.
- IV. NETWORK PLANS MUST BE REQUIRED TO DEMONSTRATE CAPACITY TO EFFECTIVELY TREAT INTRACTABLE PAIN AND SIMILAR ILLNESSES WITHIN THEIR OWN NETWORK, OR THROUGH REFERRAL ARRANGEMENTS OUTSIDE THE NETWORK, AND PROVIDE OUTCOME DATA TO PROVE EFFECTIVENESS.
- V. REFERRAL ARRANGEMENTS MUST BE TARGETED TO PROPERLY TRAINED PRACTITIONERS, ACADEMIC CENTERS, AND "CENTERS OF EXCELLENCE" WHICH SPECIALIZE IN THE TREATMENT OF INTRACTABLE PAIN AND SIMILAR ILLNESSES.

- VI. FEE SCHEDULES MUST RECOGNIZE THE SCOPE AND INTENSITY OF SERVICES DELIVERED BY SPECIALTY PRACTITIONERS AND MULTI-DISCIPLINARY TEAMS TO PATIENTS WHO HAVE FAILED TO RESPOND TO CUSTOMARY AND USUAL CARE. UNTIL APPROPRIATE SCHEDULES ARE DEVELOPED, BALANCE BILLING BY SPECIALTY PRACTITIONERS, ACADEMIC CENTERS AND CENTERS OF EXCELLENCE SHOULD BE PERMITTED.

HUBERT ROSOMOFF, M.D.
President, American Pain Society

PETER WILSON, M.B.B.S., Ph.D.
President, American Academy of Pain Medicine

SEYMOUR SOLOMON, M.D.
President, American Association for the Study of Headache

Adopted: October 1993

Mr. McDERMOTT. Dr. Walsh.

STATEMENT OF JAMES K. WALSH, CHAIRMAN, COMMITTEE ON GOVERNMENT AFFAIRS AND PUBLIC POLICY, AMERICAN SLEEP DISORDERS ASSOCIATION

Mr. WALSH. Mr. Chairman, thank you for the opportunity to present the views of the American Sleep Disorders Association on health care reform.

The ASDA is an organization of 2,500 physicians and researchers which is here to speak on behalf of the tens of millions of Americans with sleep disorders, such as sleep apnea, narcolepsy, chronic insomnia and sudden infant death syndrome.

The American Sleep Disorders Association supports the basic principles of health care reform outlined in the President's proposal. However, there are specific items within the proposal about which we are concerned and we would like to bring to your attention.

The first issue deals with further Medicare cuts. Under the current physician fee schedule, Medicare reimbursement for polysomnography, which is the primary procedure used to diagnose sleep disorders, is only one-third of the cost of performing these tests. This is one-third of the physician cost, not the patient charge. Eighteen months of negotiations with HCFA has not been helpful in this matter. Given the high prevalence of sleep disorders among the elderly, further cuts in the Medicare program threaten to make our seniors second class citizens. We believe that Medicare should not be the target of further cuts.

The second issue we wish to address deals with the health care work force and training programs. Despite the acknowledged need for primary care physicians and other health professionals, the ASDA is concerned about a system which would establish disincentives for talented health professionals to pursue specialty training. Because the medical field of sleep medicine is relatively new, such disincentives would severely limit the development of a core group of specialists to treat the millions of Americans with undiagnosed, untreated sleep disorders.

Improved quality of American health care cannot result only from universal coverage and reduced cost; it must also include the large amounts of benefits to special areas of expertise.

The third issue we wish to address is disease prevention and cost containment. Early identification and treatment of sleep problems will dramatically reduce the morbidity associated with disorders, such as narcoleptic automobile accidents. It will also allow for early treatment of depressive illnesses. It will reduce the number of patients with hypertension and other cardiovascular illnesses. The morbidity associated with sleep disorders is widespread and largely preventable.

Our final area of concern is the expected limitations on benefits for procedures not specifically identified in the basic benefits package. Because of the lack of awareness about sleep disorders, it is very easy to imagine a health insurer arbitrarily eliminating coverage for a diagnosis and treatment of sleep disorders. Similarly, it is just as likely that managed care organizations would place a very low priority on securing the services of a sleep medicine spe-

cialist or on providing sufficient resources under our capitated system.

Mr. Walsh. We must not allow the dramatic impact of sleep disorders upon the quality of life of our citizens to be ignored by our Nation's health care plan.

Mr. Chairman, Congress recognized the importance of sleep disorders in America when it established first the National Commission on Sleep Disorders Research and now the National Center for Sleep Disorders Research, at NIH. Now, when we are undertaking the vital issue of health care reform, public policy leaders who have taken the responsibility to awaken the world to the importance of sleep disorders must not allow our Nation's health policies to slip back into the darkness of ignorance about a state in which we spend one-third of our lives.

Thank you for allowing the ASDA to express its views.

[The prepared statement follows:]

**TESTIMONY OF JAMES K. WALSH, Ph.D.
CHAIRMAN
COMMITTEE ON GOVERNMENT AFFAIRS AND PUBLIC POLICY
OF THE
AMERICAN SLEEP DISORDERS ASSOCIATION**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the American Sleep Disorders Association on health care reform.

The ASDA is an organization of 2500 clinicians, researchers and technologists that is here to speak on behalf of the millions of Americans who suffer from a chronic sleep disorder.

The National Commission on Sleep Disorders Research, which issued its report to Congress earlier this year, found that at least 40 million persons in the United States suffer from a variety of life-threatening sleep-related problems.

Among the most common sleep disorders are:

- 1) **Sleep apnea**, which affects 10 million Americans, causes an individual to stop breathing frequently during sleep--sometimes as many as a hundred times a night. The resulting loss of oxygen and cardiopulmonary distress can lead to heart attacks, high blood pressure, and death from cardiopulmonary complications. Some of the most devastating effects of sleep apnea are compounded during the day when persons suffering from the disorder attempt to function in society when they are physically and mentally impaired by a lifetime of insufficient sleep, leading to errors in judgment at the worksite, carnage on the highways, or falling asleep at work or during a conversation.
- 2) **Narcolepsy** is a disorder in which an individual lives in a constant state of sleepiness, no matter how much sleep may have been obtained the night before. Persons with narcolepsy are prone to falling asleep at inappropriate times, having vivid dream states, and attacks of cataplexy in which all of their muscle tone is lost, causing paralysis. Over 250,000 Americans are afflicted by this neurological disorder for which there is no effective treatment.
- 3) **Persistent insomnia** affects 30 million American adults each year, and is often a symptom of an underlying serious illness such as depression.
- 4) **Sudden Infant Death Syndrome** claims the lives of approximately 7000 otherwise healthy infants each year and is a devastating disorder about which very little is known.

These are just four of the more than seventy sleep disorders reported by the National Commission.

The American Sleep Disorders Association embraces the principles of health care reform outlined in the Clinton proposal. For too long, too many citizens of this nation have not had access to health insurance or to the abundant technology and medical advances that make our medical capabilities the best in the world.

Many individuals who suffer from untreated sleep disorders find themselves displaced frequently in their careers because of their inability to function in today's fast moving society. Because of their employment challenges and therefore lack of access to the health care system, many go untreated. In fact, through a combination of their inadequate resources and a lack of sufficient training to recognize sleep disorders among the medical profession, the average person with a sleep disorder goes seven years before they are even diagnosed, much less adequately treated.

It is hoped that the work of the National Commission on Sleep Disorders Research will help to reverse this pervasive river of ignorance about sleep disorders and encourage public policies, medical training, and public awareness that will lead to those with sleep disorders being more adequately diagnosed and treated for their conditions.

Mr. Chairman, beyond our support for the basic principles of health care reform, there are several specific items within the proposal about which we are concerned that we would like to bring to your attention:

1) Medicare cuts: Under the physician fee schedule, Medicare reimbursement for polysomnography, the primary diagnostic test used to diagnose a sleep disorder, is only about one-third (1/3) of the cost of performing the test. That's cost, not price. Further cuts in the Medicare program threaten to make our nation's senior citizens second-class citizens. Our organization would argue that a system that is already overtaxed should not be the target of further cuts. The ASDA has been in negotiations with HCFA for 18 months around the low valuation of polysomnography. HCFA has not addressed the valuation problems of polysomnography and RBRVS. The nation's seniors may be under-RVUed out of sleep medicine care.

2) Health care workforce and training: Despite the acknowledged need for more primary care physicians and other health professionals, those in the sleep disorders field would express dire concern about a system that is geared toward establishing disincentives for talented health professionals to pursue specialty training. Because the medical field of sleep disorders is a relatively new one, we believe such disincentives would severely limit the development of a core group of specialists to treat the millions of Americans with undiagnosed sleep disorders. The result of a lack of access to diagnosis and treatment of sleep disorders is continued persistent medical problems for those persons whose suffering could be identified and successfully treated.

3) Health Alliances, PPOs, and HMOs: An underlying concern of patients suffering from sleep disorders and the physicians who treat them is the expected squeeze on benefits for those procedures not specifically identified in the basic benefits package. For example, at the Health Net capitated system at Scripps Clinic, the percentage of outpatient dollars allotted for all of sleep medicine is 0.3%. However, current epidemiological data suggest a requirement 10 times higher. Because of the lack of awareness about sleep disorders among the public and health care professionals, it is very easy to imagine a health insurer arbitrarily eliminating coverage for diagnosis and treatment of sleep disorders. Furthermore, it is just as easy to imagine that a managed care system, a preferred provider organization, or a health maintenance organization would place a very low priority on securing the services of a qualified sleep specialist. In any prepaid, capitated system, adequate allotment of funds for sleep medicine must be assured by Congress.

Mr. Chairman, Congress recognized the importance of sleep disorders in America when it established the National Commission on Sleep Disorders Research which identified the pervasive national problems in health, occupation and transportation safety, and general wellbeing associated with sleep disorders. Notwithstanding the laudable principles of the health reform proposal, some of the detailed recommendations appear to insure the opposite effect. Public policy leaders who have awakened the world to the importance of sleep disorders must not allow our nation's health policies to slip back into the darkness of ignorance about something we spend one-third (1/3) of our lives doing.

We hope that you will carefully consider our testimony when deliberating health reform legislation.

Mr. McDERMOTT [presiding]. Thank you.
Mr. Thomas.

**STATEMENT OF PETER W. THOMAS, LEGISLATIVE DIRECTOR,
AMPUTEE COALITION OF AMERICA**

Mr. PETER THOMAS. Thank you, Congressman McDermott.

In the last panel we discussed chronic illnesses, but I would suggest that there is also a whole other range of conditions that are not necessarily chronic illnesses but are still long term in nature and require long-term services. I speak specifically with regard to the use of prosthetic and orthotic devices or artificial limbs and orthopedic braces.

I am representing the Amputee Coalition of America today, which represents about 10,000 direct members and serves as the national voice for over 2 million amputees nationwide. We testified last spring before this Subcommittee on the issue of basic benefits and I am very happy to report that the administration has chosen to include prosthetic and orthotic devices in the standard package.

Just very briefly, personally I wear two artificial limbs below the knees. I was in a car accident at the age of ten. Since then, I have had 12 different sets of artificial limbs over the 19 years that I have had them, from eight different providers throughout the country, representing about five different States. I currently have found a specialist in Florida who is well adapted to my particular disability and does well with my prosthetic care.

A major concern that many amputees have under health care reform is the inability to locate and the inability to travel to the provider of choice. That is an acute concern of many amputees who have found proper rehabilitation in a specific area throughout the country, often far from their homes.

The ACA supports President Clinton's health care reform proposal in many respects, specifically in the area of benefits, but we also have some questions about quality. In the area of benefits, we strongly support universal coverage, not just universal access. We feel this is a key element of any health care reform plan that emerges from Congress.

Currently, the comprehensive benefits in the President's plan seem quite good, although we would stress that replacements of artificial limbs need to be included for more than just changes in physical condition. Replacement limbs need to be included for changes in one's technology and due to wear and tear as well.

We support an employer mandate and we support reform of inequitable insurance practices. As far as quality goes, there are incentives for underservice in HMOs and managed care type situations, and we strongly support point-of-service options.

We oppose "single-source" providers and mandates that only certain providers within a network can provide a particular type of device. We support a requirement that AHP's offer a wide selection of qualified orthotic and prosthetic practitioners, preferably certified by the American Board for Certification in Orthotics and Prosthetics.

But even if this is the case, amputees and people with disabilities who require orthotic and prosthetic devices should be able to go outside a network in order to access the services that they need,

especially if the fee is the same as the in-network service. And if it is not the same, then the point-of-service option should not be so financially burdensome as to really eliminate that choice.

Last, competitive bidding is a problem in prosthetic and orthotics, whether it is in the Medicare program or in private insurance, primarily because you are dealing with a very customized and individualized item that needs to be designed and fit for each particular amputee or each particular person with a disability. Competitive bidding in this situation greatly compromises quality care.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF PETER W. THOMAS
LEGISLATIVE DIRECTOR
AMPUTEE COALITION OF AMERICA**

Distinguished Chairman and Members of the Subcommittee:

My name is Peter W. Thomas and today I address the Subcommittee on behalf of the Amputee Coalition of America (ACA), a national non-profit coalition of amputee support groups and related organizations representing the interests of over 10,000 consumer members. The ACA serves as the national voice for over 2 million amputees and millions of people with physical disabilities. Most of our members utilize artificial limbs (protheses) and orthopaedic braces (orthoses) in order to maintain mobility, employment, and a high quality of life.

I became a double amputee below the knees in the Summer of 1974 at the age of ten due an automobile accident. I have had 12 sets of artificial limbs over 19 years from 8 different providers throughout the country. After finally identifying a prosthetist in Florida who is able to service my particular prosthetic needs, I have been able to play golf, downhill ski, walk long distances and pursue a career in law. I will be married in May, 1994 and plan to raise a family.

This could not have been possible if I were unable to access good prosthetic health care services. Since the date of my accident, I have seen first-hand the vast improvements in prostheses and orthoses, and as a consequence, the improved ability to function of this nation's amputees and people with physical disabilities. Modern artificial limbs allow amputees to perform employment, fitness, and recreational activities in ways they only dreamed about just a few short years ago. The Amputee Coalition of America strongly supports health care reform, particularly those reforms that will increase access to quality prosthetic and orthotic devices for those who need them. An overarching concern of the ACA, however, is that the quality and technological superiority of recent generations of artificial limbs and orthopaedic braces are not placed in jeopardy as this nation attempts to reform its health care system.

The cost effectiveness of good prosthetic and orthotic management cannot be understated. Quality prosthetic and orthotic care can virtually neutralize the disabling effects of physical impairments and maximize an individual's ability to function at the job, in school, and in the home. A recent study conducted by the University of Miami School of Medicine found that a \$6,000 investment in a functional, modern artificial limb saves an estimated \$430,000 over a five year period in medical expenses due to other debilitating complications, lost productivity, and government income maintenance, to say nothing of the quality of life. In a very real way, modern prosthetic and orthotic care can mean the difference between a life of dependency and independency.

I. The Specialized Nature of Prosthetics and Orthotics:

Prosthetics and orthotics are often inappropriately considered under the broader category of durable medical equipment (DME). Unfortunately, this has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. Quality prosthetic and orthotic care is as much a professional service as it is a device that results from this service. All prostheses and most orthoses are custom designed and fit to the particular medical and functional needs of the patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes, and complex contours, is fundamentally different from most types of durable medical equipment and should be treated separately from DME in legislation and in regulation.

In addition, significant variations exist in the delivery of quality prosthetic and orthotic services, primarily due to the explosion in technology over the past decade. The prosthetic and orthotic profession has a defined body of clinical and technical knowledge and a core of 2,800 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at

eight major American universities. All of these factors justify specialized treatment for prosthetic and orthotic services in health care reform legislation. Before we explore prosthetic and orthotic issues in the context of President Clinton's health care reform proposal, however, let us state our positions on several key aspects of health system reform.

II. Universal Coverage is the Key to Reform:

The Amputee Coalition of America strongly favors health care reform that provides universal coverage of comprehensive benefits. As President Clinton has stated, universal coverage and comprehensive benefits should not be negotiable issues throughout the health care reform debate. ACA believes that this nation has a historic opportunity to reform our health care system that must not be missed. Too many of our fellow citizens are unable to access the quality health care they need when they need it most. This is particularly true in the case of people with disabilities who have been systematically discriminated against in the provision of health insurance throughout this century. The ACA believes, however, that universal coverage, not simply universal access, is a key component of successful health care reform. Health care proposals that do not contemplate universal coverage of a comprehensive package of benefits within the next few years simply do not go far enough in terms of reform.

III. Reforming Inequitable Insurance Practices:

We must build on our current health insurance system with an employer mandate, with appropriate subsidies for small businesses and low income individuals, and significantly alter the current insurance practices which impede access to quality health care services. Pre-existing condition exclusions have long been the nemesis of people with disabilities, particularly users of orthotic and prosthetic devices. These inequitable exclusions must be eliminated in a reformed health care system. Community rating with appropriate risk adjustments must replace the inequities of experience-based premium rating. This method of insurance premium rating has long been used to exclude people with disabilities from sufficient health insurance coverage. Health insurers must no longer be able to "cherry pick" the best health customers with the lowest health care risks, excluding frequent users of health care from coverage. Risk adjustments must be properly and accurately determined in order to appropriately compensate health care providers and insurance companies for additional costs associated with frequent users of health care services. Calculating an accurate risk adjustment to reflect the true costs of specialized care is critical to the success of health care reform.

The ACA strongly supports the Clinton Plan's annual out-of-pocket spending limit of \$1,500 per individual and \$3,000 per family. This goes a long way toward the provision of health security for all Americans. The ACA is concerned, however, that these spending levels may be out of reach of many lower-income Americans. The ACA would prefer that these annual spending limits be adjusted to a person's level of income.

IV. Orthotic and Prosthetic Priorities Under the Clinton Plan:

The ACA believes that the Clinton Plan represents the most comprehensive and viable approach to accomplishing the goals of universal coverage, increased access, and enhanced quality of health care services. Overall, the Clinton Plan has the potential to greatly enhance health care for people with disabilities. The prosthetic and orthotic community, however, has several areas of concern in the two general areas of coverage and quality that we would like to see addressed in the Congress.

A. Maintaining a Comprehensive Benefit Package.

A comprehensive standard benefit package is critical to the success of a reformed health care system under the Clinton Plan. As pressure mounts in Congress to limit the cost of health care reform, ACA urges the Members of this Subcommittee to resist efforts to limit the nature, scope, and duration of the Clinton Plan's standard benefit package.

Prosthetics and orthotics are currently included as standard benefits in the Clinton Plan. According to the legislation, "leg, arm, back and neck braces, artificial legs, arms and eyes" including "replacements if required due to a change in physical condition" are included as standard benefits. Training for the use of prostheses and orthoses is also included which recognizes one important aspect of the service component of prosthetic and orthotic care. Additionally, the Clinton Plan includes in the standard benefit package "accessories and supplies used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device." We strongly support this language and urge an explicit extension to orthotic accessories and supplies.

B. Replacements of Prostheses and Orthoses.

Many private insurance policies currently do not cover replacements of prostheses and orthoses. This results in the absurd situation where an amputee, for instance, is expected to function on one artificial limb per lifetime, with no regard to age, growth, changes in medical or functional needs, simple wear and tear or significant advancements in technology. The Clinton legislation effectively eliminates this unscrupulous practice whenever a change in a person's physical condition exists. The ACA believes that prosthetic and orthotic replacements should also be covered as a standard benefit due to normal wear and tear and if advancements in technology have the potential to significantly improve prosthetic and orthotic outcomes.

C. Quality Care Under Capitated Health Plans:

Under the Clinton Plan, every employer would be required to offer three different types of health plans to their employees; an HMO-type plan, a PPO-type plan, and a fee-for-service plan, with varying levels of premiums, co-payments, and deductibles. There would be an open enrollment period each year for consumers to switch from one plan to another if they are not satisfied with the level of care. This would afford many Americans with greater choice than they now have to choose the type of plan that suits their needs. ACA is very concerned, however, that the Clinton Plan's heavy reliance on managed care will result in compromised quality of prosthetic and orthotic care. Because the health insurance industry is heading toward greater use of managed care on its own account, the health care reform debate is an excellent opportunity to establish industry standards that will both hold down costs and preserve the quality of health care in managed care arrangements.

Simply stated, capitated health care delivery systems create great incentives to underserve participants in the plan, particularly individuals needing specialized or expensive health care services. Presumably, a risk adjustment mechanism will attempt to compensate health plans for high-cost users of care. If this risk adjustment does not adequately reflect and account for the true costs of care for specialized or costly services, health plans will have an incentive to develop a poor reputation for servicing the needs of these populations, so as not to attract additional participants requiring these services. It is critical that any prospective risk adjustment is set at levels that adequately compensate health plans for the true costs of specialized services to all participants in a plan, but particularly to individuals requiring prosthetic and orthotic services.

D. Competitive Bidding Should Not Apply to Prosthetics and Orthotics:

The Clinton Plan does not subject prosthetics and orthotics to competitive bidding in the Medicare program, but allows the Secretary of HHS to determine which services under Medicare will be competitively bid in the future. Due to the highly specialized and customized nature of prosthetic and orthotic services, competitive bidding for these services would directly and immediately result in a decrease in quality. Standard items and off-the-shelf devices lend themselves more readily to competitive bidding because providers can compete based on efficiency of their business operation. This is not the case with customized devices. Lesser quality services and lesser functional devices will be the inevitable and immediate result of competitive bidding in the provision of prosthetics and orthotics, whether it be in the Medicare program or in private health plans.

E. Selection of Qualified Orthotic and Prosthetic Practitioners:

An alarming trend in managed care is that health networks are contracting with one or two prosthetic and orthotic providers in a geographical region in order to achieve efficiency and bulk purchasing power. This often disrupts long-standing patient-practitioner relationships and does not adequately recognize the specialized nature of prosthetic and orthotic services. A decrease in quality care and patient satisfaction is often the result. The Clinton Plan currently preempts State laws that prohibit health plans from establishing "single source providers" such as pharmacies and providers of "medical equipment." Accountable Health Plans should not be allowed to contract with single source providers in the area of prosthetics and orthotics. In order to ensure quality, specialized prosthetic and orthotic care in capitated health care plans, each plan should be required to offer a wide selection of qualified prosthetists and orthotists who are certified to practice in accredited facilities. Because of the specialized nature of these services and to protect health care consumers, the credentialing body for these functions must be the American Board for Certification in Orthotics and Prosthetics.

All health plans should be required to offer a "point of service" option to plan participants and cover prosthetic and orthotic services from qualified providers outside of a plan's geographical area. This is especially true if the practitioner is willing to provide the service at an equivalent fee of a provider within the plan's geographic area. Even if the fee for an out-of-network provider is not equivalent to the network provider, prosthetic and orthotic consumers should be able to access providers outside of their network if it is medically and functionally necessary to do so, without financial penalty. A prosthetic or orthotic consumer should not be required to exhaust every provider within the network before being able to access care outside of the network. This practice is wasteful and costly. This special treatment for prosthetic and orthotic providers is justified by the specialized nature and individuality of prosthetic and orthotic services, the expertise of which often lies in different states and regions of the country.

Mr. McDERMOTT. Thank you.
Mr. Cordaro.

STATEMENT OF J.B. CORDARO, PRESIDENT, COUNCIL FOR RESPONSIBLE NUTRITION

Mr. CORDARO. Thank you, Congressman McDermott. It is a privilege to appear before this distinguished subcommittee.

My name is J.B. Cordaro. I am the president of the Council for Responsible Nutrition, an association of the manufacturers of nutritional supplements, ingredients and other nutritional products. We thank you for this opportunity to discuss the important topic of prevention and the role of nutritional supplements in promoting health and reducing health care costs.

The current debate on health care reform involves complex factors, but one rather simple fact deserves more attention. If we can move our citizens to improve their health conditions through education and personal responsibility, we can save hundreds of billions of dollars in health care costs. If we can stimulate awareness and provide consumers with access to products and information on dietary supplements, that will help them maintain an improve good health and prevent disease, then we can save billions of dollars each year in health care costs avoided.

Mr. Chairman, over 100 million Americans use dietary supplements, and millions more should be using these products. Scientific evidence is mounting that generous intakes of certain vitamins and minerals can protect against a number of diseases such as cancer, heart disease, neural tube birth defects, osteoporosis and cataracts.

An inexpensive multivitamin with folic acid, taken daily by females of child-bearing age before and during the first 3 months of pregnancy, can prevent from 50 to 75 percent of neural tube birth defects such as spina bifida.

Several other examples demonstrate the relationship between vitamins and minerals and the protection against disease. Generous intakes of calcium have been shown to increase bone density and reduce the risk of osteoporosis. Increased intakes of vitamin C and E and beta-carotene could potentially prevent or postpone 50 to 75 percent of cataracts. Diets high in antioxidant vitamins have been shown to reduce the incidence of cancer. Vitamin C appears especially beneficial in protecting against stomach cancer and beta-carotene is strongly protective against lung cancer.

Mr. Chairman, the council recently commissioned a study which found that our Nation's health care system could save \$8.7 billion annually from reduced hospitalizations resulting from five major diseases if Americans consumed optimal levels of the antioxidant vitamin C, E and beta-carotene. These figures represent only a portion of the potential savings. Unfortunately, the Food and Drug Administration remains intent on choking off the dissemination of nutrition and health information which consumers could use to make decisions on their diet.

Congressional guidance is needed to modernize FDA's regulation of dietary supplements. There is a way. Currently moving through the Congress is the Dietary Supplement Health and Education Act of 1993, S. 748 as introduced by Senator Hatch and H.R. 1709 as introduced by Congressman Bill Richardson.

Dietary supplement users are counting on Congress to protect their access to safe, beneficial products, and scientific information on the value of these products. We look forward to working with the Congress and the administration in underscoring a role for dietary supplements as a part of our national health security.

Supplements can, and will play, a useful role in disease prevention and corresponding reductions in health care costs without substantial new government expenditures.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**TESTIMONY OF J.B. CORDARO
PRESIDENT
COUNCIL FOR RESPONSIBLE NUTRITION**

Thank you, Chairman Stark. It is a privilege to appear before your distinguished Subcommittee, which has such an important responsibility to our nation in shaping our health care system.

I am J.B. Cordaro, President of the Council for Responsible Nutrition (CRN), an association of manufacturers of nutritional supplements, ingredients, and other nutritional products. On behalf of CRN and its members, I thank you for this opportunity to discuss the important topic of prevention and the role of nutritional supplements in promoting health and reducing health care costs.

The current debate on health care reform involves complex factors, but one rather simple fact deserves more attention. If we can move our citizens to improve their health conditions through education and personal responsibility, we can save hundreds of billions of dollars in overall health care costs.

People are beginning to realize that our health care system, which leads the world in high-technology medicine, has been far less successful in fostering preventive medical care. With this Subcommittee's help, Congress has recently acted to improve the availability of childhood vaccines, and we wish to identify another area in which Congress can act to boost prevention at very little cost but with great cost savings.

If we can stimulate awareness and provide consumers with access to products and information on dietary supplements that will help them maintain and improve good health and prevent disease, we can save billions of dollars each year in health care costs avoided.

Mr. Chairman, over 100 million Americans use dietary supplements and millions more should be using these products. Scientific evidence is mounting that generous intakes of certain vitamins and minerals can protect against a number of disease conditions, including cancer, heart disease, neural tube birth defects (such as spina bifida), osteoporosis, and cataracts.

An inexpensive multivitamin with folic acid (one of the B vitamins) taken daily by females of childbearing age, before and during the first three months of pregnancy, can prevent from 50 percent to 75 percent of neural tube birth defects such as spina bifida.

Mr. Chairman, we ought to sound loudly the collective voice of our federal government and urge every female of childbearing age to take this simple step. In so doing, we would dramatically reduce downstream health care costs and spare 100 such birth defects each month. And, it wouldn't require a new federal program or additional federal expenditures.

There are several other examples I would call to this Subcommittee's attention:

- Generous intakes of calcium have been shown to increase bone density and reduce the risk of osteoporosis.
- Increased intakes of vitamins C and E and beta-carotene could potentially prevent or postpone 50 to 70 percent of cataracts.
- Diets high in antioxidant vitamins have been shown to reduce the incidence of cancer. Vitamin C appears especially beneficial in protecting against stomach cancer, and beta-carotene is strongly protective against lung cancer. A recent analysis of 12 published studies on breast cancer concluded that 16 percent of these cancers in postmenopausal women might have been prevented if the women had consumed 380 mg of vitamin C per day.
- Two recent Harvard University studies demonstrated that men and women who had used vitamin E supplements for a minimum of two years had about a 40 percent reduction in the risk of heart disease.

Mr. Chairman, CRN commissioned a recent study by Pracon, Inc., a Reston, Virginia economic analysis firm, which found that our nation's health care system could save \$8.7 billion annually merely from reduced hospitalizations resulting from five major diseases if Americans consumed optimal levels of the antioxidant vitamins C and E and beta-carotene.

The Pracon study also concluded:

- For coronary heart disease related hospitalizations, Vitamin E supplements have the potential to save:

\$1.5 billion for Medicare; \$7.7 billion for the United States annually.

- For breast, lung, and stomach cancer hospitalization avoidances, diets optimal in antioxidant vitamins C and E and beta-carotene may yield:

\$196.4 million in savings for the Medicare program; \$1.0 billion or more in savings for the United States annually.

- By preventing 50 percent of cataract hospitalizations, optimal intake of vitamins C and E and beta-carotene may save:

\$7.1 million for the Medicaid program; \$94.3 million for the United States annually.

Over a period of five years, this savings would amount to \$43.5 billion. And these figures represent only a portion of the potential savings because hospitalizations represent only one piece of the total medical costs of the diseases studied.

In addition to the Pracon report, a recent study announced at the American Heart Association's annual meeting on November 8, 1993, and conducted by Boston's Brigham and Women's Hospital, found that eating foods rich in the antioxidant vitamins C and E and beta-carotene may help prevent heart attacks and strokes in women. It was revealed that those women who had the highest antioxidant consumption had a 33 percent lower risk of heart attack and a 71 percent lower risk of stroke, compared to women who ate the least amount of antioxidant-containing foods.

As you can see, both of these studies are quite impressive. Unfortunately, however, as more and more Americans continue to be attentive to what they eat and are more involved in using dietary supplements to maintain a healthy lifestyle, the Food and Drug Administration (FDA) remains intent on choking off the dissemination of nutrition and health information which consumers could use to make decisions on their diet. Because of this, it is apparent that Congressional guidance is needed to modernize FDA's regulation of dietary supplements. It's time that Congress bring FDA into the 20th century, before the rest of us enter the 21st century!

FDA's refusal to acknowledge the important role supplements can play in preventing disease and promoting optimal health presents serious impediments to the appropriate regulation of these products and has resulted in regulatory confusion. This confusion has created bewilderment for the over 100 million consumers of dietary supplements and for those additional millions who should be using supplements to enhance their health. There is a real need to establish a regulatory framework that benefits consumers.

There is a way, however, to help correct this situation. Currently making its way through the Congress is legislation, The Dietary Supplement Health and Education Act of 1993, S. 784, as introduced by Senator Hatch, and H.R. 1709, as introduced by Representative Richardson. S. 784 is cosponsored by more than 60 Senators and H.R.

1709 currently enjoys the support of nearly 200 cosponsors. These bills recognize the valuable role nutritional supplements play in health promotion and open the way for consumers to obtain the information they need to make healthy dietary choices. At the same time, the bills challenge the supplement industry to continue to ensure the safety and quality of its products.

CRN believes that this legislation represents a reasonable, rational, and fair approach for the Congress to provide direction to FDA while preserving the rights of responsible manufacturers. Dietary supplement users are counting on the Congress to protect their access to safe, beneficial products and scientific information on the value of these products.

Clearly, Americans are demanding change in our health care system. While many aspects of health care reform are far from settled, growing support by way of documented scientific studies, like those referenced here today, lend credence to mounting evidence that nutritional supplements can offer potentially significant benefits to users. This Subcommittee knows that prevention is an important component that will ultimately affect the price and capability of our health care system.

Consensus building in health care reform will benefit from debates and informed discussions like today's hearing. CRN stands ready to provide input and counsel when appropriate. As an advocate of increased emphasis on wellness and prevention, CRN believes that prevention, education, and health choices are inter-related. Any meaningful health care reform must take into account the ability to balance preventive care with appropriate means. Understandably, nutritional supplements will continue to be the subject of much study and discussion.

We look forward to working with the Congress and the Administration in underscoring a role for dietary supplements as a part of our national health security. Supplements can, and will, play a useful role in disease prevention and corresponding reductions in health care costs without substantial new government expenditures.

Mr. McDERMOTT. Thank you very much.
Mr. Burd.

STATEMENT OF RONALD P. BURD, PRESIDENT, DEVEREUX FOUNDATION

Mr. BURD. Thank you. Mr. Chairman, thank you for this opportunity to be heard.

I am Ronald Burd, president of the Devereux Foundation. In the formal statement I am inserting, with your permission, in the record, we have set forth our specific expertise and recommendations.

President Clinton's proposed expansion of the availability of mental health services offers a good start, worthy of support, despite its limitations. But in the brief time allotted to me today, I want to focus your attention on the most overlooked, underrepresented, powerless, helpless group of patients in our society today, children with emotional and behavioral disorders. They have no lobbyists, no PAC, no vote. They are usually the last to be brought in when health care legislation is prepared, and the first to be squeezed out when budgetary concerns take over.

Yet, who among us would willingly trade places with those children or their parents? Who among us who has not personally borne the burden those parents bear can blithely talk about limiting the care those children can receive?

I have heard the cries for help from countless parents, teachers and public agencies. No other childhood illness, not one, causes greater disruption to families, schools, communities, and above all the children themselves. Maligned, mistreated, sometimes destructive, but nevertheless innocent, suffering kids who have no chance without treatment. No other childhood illness, if left untreated, is more potentially debilitating for the rest of that child's entire life, and no other childhood illness, if left untreated, is more expensive for that child's family, communities, State and Nation.

Today, professional treatment of those children, not confinement, not punishment, but modern medical and clinical treatment can work wonders. It takes time, it takes money, but childhood mental illness treated early and adequately need no longer last a lifetime. The hope for recovery, ranging from full rehabilitation to at least some modest joy in the quality of life, is no longer a futile hope.

Let me tell you about Sandra, age 16, who came to us from a juvenile detention facility, having been involved with various public agencies since the age of nine. After early emotional problems escalated into running away, drug abuse and self-injurious behavior, and after expulsion from a child welfare facility, Sandra's family took her to a large psychiatric hospital where her stay was funded through her father's private health insurance policy. It limited residential psychiatric treatment to 30 days.

At the end of that period, having been returned home as cured, she immediately attacked her mother with a kitchen knife and was placed in the juvenile facility that referred her to Devereux. In the 3 months that she was been with us, progressing from restrictive psychiatric hospitalization to less restrictive settings and now to a group home, Sandra has improved substantially to the point that

she finally feels safe enough to talk about the physical and sexual abuse she suffered at the hands of her two older brothers.

For 8 years, after she experienced that horror, she continually received inappropriate treatment and thus continued to act on the urges caused by her trauma, including glue sniffing that resulted in organic brain damage. Those 8 years of personal pain and significant societal expense could have been avoided with early effective treatment.

That is why I plead with this committee to include in the standard health benefits package a mental health component for children under the age of 18 that has no arbitrary limits on the number of days of either inpatient or outpatient treatment.

I address this appeal not only to the Nation's conscience to heed the plight of the least among us, but also the Nation's pocketbook. Turning our backs on those children will not save money. It will cost money, big money, tax money. Money for long-term custodial institutions and prisons, money for welfare and special education, money to meet the costs of more dysfunctional families and more crime and more homelessness, more violence on the streets and in our schools.

I understand the need to limit the overall cost of the new health care system, but denying adequate treatment to mentally ill children will in time increase those costs. Too many of those children untreated will be unable to care for themselves as adults and unable to gain the minimal education and employment necessary to pay taxes, doctors, or hospitals.

Do not think those costs fall only on State and local governments. Federal funds are increasingly required to help schools cope with mentally afflicted children under the Individuals with Disabilities Education Act, to help pay for poor mentally ill children under Medicaid, to help local police and criminal justice systems under several programs.

A fully funded mental health benefit for children would bring enormous long-term benefits to this country, to our productivity and social stability, to our economic and physical well-being, and to our pride and dignity as caring people.

Mr. Chairman, do not place these harsh and arbitrary limits on mental health services for children. To do so would be fiscally unwise, medically unjustified, and socially unsound. Above all, it would be wrong.

Thank you again for this opportunity to be heard.

[The prepared statement follows:]



Arizona
California
Connecticut
Delaware
Florida
Georgia
Maryland
Massachusetts
New Jersey
New York
Pennsylvania
Texas

**TESTIMONY OF THE DEVEREUX FOUNDATION
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
OF THE UNITED STATES HOUSE OF REPRESENTATIVES
NOVEMBER 15, 1993**

Thank you for this opportunity to present the views of the Devereux Foundation on the benefits contained in the Administration's proposal for health care reform. Our comments will focus on the mental health and long-term care provisions.

Devereux commends the Administration for proposing substantial and meaningful improvements in the services available to many persons with mental illness or with developmental disabilities. While this package is not perfect, and while we would like to suggest certain changes to the benefits initially made available, we nonetheless believe this proposal is an important start and worthy of support.

Background on Devereux

Devereux, founded in 1912, is a nationwide non-profit network providing a continuum of high quality treatment services to children, adolescents, and adults who have a wide range of emotional disorders, developmental disabilities, or both. Headquartered in Devon, Pennsylvania, Devereux operates psychiatric hospitals, residential and day treatment programs, school and vocational programs, community-based group homes, therapeutic foster care, as well as individual and family outpatient services through 22 centers located in 13 states and the District of Columbia. This broad array of services and settings -- from the most protective to the least restrictive -- makes Devereux the largest, most comprehensive non-profit organization of its kind in the nation, and the provider of choice in many states for children and youth.

Understanding that clients have varying abilities, goals and backgrounds, Devereux's multi-disciplinary teams design individualized treatment programs to ensure that each client's experience is therapeutic. Activities are designed to encourage success and achievement and to discourage frustration and failure. The organization's philosophy reflects the legacy of the founder, Helena T. Devereux, a pioneer special educator, who believed that "every child is a program."

Devereux's Perspective on Health Care Reform

Devereux agrees generally with the "Recommendations for Mental Health Services in Health Care Reform" endorsed by 31 national organizations on March 5, 1993. Our analysis of the Administration's plan has prompted us to offer more extensive and more specific recommendations to improve systems of care and services for people with serious emotional and developmental disabilities. The recommendations which begin on page 6 are organized in two broad diagnostic categories, developmental disabilities and emotional disturbances, as well as a section on specific needs for research and demonstration efforts. A summary of recommendations appears on page 6.

We see three critical challenges facing reform legislation which bear mentioning at the outset.

First, attention is urgently needed to coordinate and improve mental health care and related services to children and youth. With more children living in poverty and more and younger children being exposed (often in-utero) to addictive drugs, Devereux is seeing damage from physical and emotional abuse at unprecedented numbers and levels. The direct and indirect costs of unmet mental health care needs, particularly in the case of children, are troubling and have been well documented. We are convinced that fiscally motivated reluctance to address these needs in a timely way with appropriate health care coverage will lead inevitably to much greater financial expense, as well as aggravated and prolonged human suffering by patients and their families.

Second, painstaking attention will be required at all levels to ensure that no harm is done by the reform program to individuals with special needs who are being served currently. Because of the tightening of funding streams at the state and local level, there is the real risk of reducing or eliminating appropriate funding for some of those with the greatest need. While this challenge was recognized by Administration planners, it is critical that Congress also recognizes the importance of effective transition mechanisms to ensure that necessary treatment under current programs is not terminated.

Third, a national initiative to research, demonstrate, develop and evaluate more effective models of treatment is needed. Specifically, reliable measurements of the effectiveness of care and treatment are necessary if managers of care are to pursue the much debated concept of "parity" between mental health coverage and other forms of health care insurance. For everyone involved in the delivery system -- funder, provider and consumer alike -- answers to questions of cost, location and length of treatment have little value without empirical evidence that the patient is, in some measurable way, getting better.

The Health Care Reform Program Should Provide Cost Effective Services for Persons with Serious Emotional Disturbances

Devereux strongly supports the goal of the Administration to provide an open, flexible mental health benefit (subject to appropriate management of the benefit) by the year 2001 as a component of the standard benefits package. As indicated by the National Advisory Mental Health Council's study of March 1993, "Health Care Reform for Americans with Severe Mental Illnesses," the cost is attractive compared to the potential long-term benefits (\$6.5 billion per year in costs compared to \$8.7 billion per year in benefits).

Devereux knows by experience that arbitrary limits¹ on treatment of persons with serious emotional disturbances are not only morally and medically undesirable but financially unsound as well. Treatment based on such limits often prolongs the mental illness that originally brought the person to the mental health care system and increases the costs to society of that illness.

Nonetheless, every proposal must accommodate difficult political realities. In our view, a proposal with some restrictions on benefits which substantially improves the current mental health services offered by most private health plans would be appropriate if: 1) a reasonable target date is established for open, flexible benefits, 2) existing programs are maintained during the transition, and 3) the special needs of children are addressed in the initial benefits package.

¹ For example, maximum numbers of days of inpatient or outpatient treatment.

The proposed 30-day/60-day limits on inpatient treatment would clearly harm some of Devereux's emotionally disturbed patients, particularly children. For some persons, inpatient care is the treatment of choice at the beginning of a continuum from psychiatric hospitalization to less restrictive residential treatment and ultimately to home-based or outpatient programs. A large number of the children that Devereux initially treats through inpatient care are indeed able to move back into their schools and homes, complete their education and live as independent and self-sustaining members of the community. The cost of effective initial treatment for a young person is more than justified when one compares it to the alternative cost of a series of episodic and ineffective interventions and possible contact with juvenile and adult corrections systems.

Our experience has demonstrated that for many children the chances of real progress are greatly enhanced with exposure to a supportive, open residential program. Such a setting in behavioral health care is referred to as "a therapeutic milieu." For example, at this writing the average total stay of a child at Devereux's Mapleton Center in Pennsylvania (which provides residential care to children with serious emotional disorders) is 17 months. During this period some Devereux clients move from "staff secure" hospital settings through open, progressively less restrictive settings, in many cases resulting in full reintegration into the community. The initial phase of psychiatric hospitalization is quite brief, usually a maximum of 30 days. In the course of this treatment, young people experience -- often for the first time -- real success and strong positive reinforcement. Treatment progress is often first seen in the open residential treatment milieu, i.e., in social functioning with adults and peers, in school work and, ideally, within the family group.

If mental health care insurance imposes arbitrary time limits on inpatient care, or does not provide for necessary related services, the therapeutic milieu experience would be limited or even precluded, and effective treatment will not be possible in many cases.

While the Administration's initial inpatient treatment limit for emotionally disturbed patients is overly restrictive, Devereux has been dealing with even more severe limits imposed by the health plans of some patients. Devereux has partially compensated for funding gaps by: 1) use of the Medicaid program by those patients who are eligible, and 2) use of public education funding under the IDEA² law for patients under the age of 21. These sources are limited, however, and large funding gaps remain for many patients. Medicaid is not available to many patients. Public education funding does not fully compensate Devereux for some of the mental health services that are essential in designing integrated programs of formal education, skills training and treatment. And for persons over 21 who are not Medicaid eligible, there is no "gap filler" at all.

At a minimum, care should be taken to ensure that no harm is done to those persons currently receiving services. While the Administration appears to have recognized this imperative in the mental health area, we must emphasize again that existing IDEA and Medicaid funding also provide essential medical services. Given current proposals to significantly reduce spending on Medicare and Medicaid in order to finance the overall health care plan, Congress should avoid cost shifts during the plan's first five years which would place the most needy patients below the

² The individuals with Disabilities Education Act ("IDEA," 20 U.S.C. §1400 et seq.) provides some funds to state and local governments for mental health services to children enrolled in schools.

present "floor" of services provided by the Medicaid and IDEA programs.

Even if these programs are maintained, major funding gaps will remain in the initial years of the Administration's plan. In order to narrow these gaps, we recommend that Congress provide for full coverage of children who need inpatient psychiatric treatment beyond the 30-day/60-day annual limits. This coverage could take the form of grants to supplement IDEA funding, a relaxation of the inpatient treatment limits for persons under 21, or any other mechanism which ensures that children with serious emotional disturbances receive clinically necessary treatment. The additional cost of providing early treatment intervention to children is justified by the significant individual and societal damage that this coverage would prevent or reduce. This cost would be more than offset by savings resulting from early and effective attention to a small class of children that have serious but treatable illnesses. If the national health plan does not fund the cost of this treatment, someone else will surely be required to pay for the consequences -- usually local schools, communities, or juvenile justice systems, as well as the individual children and their families.

There has been much debate over the cost of the mental health benefit. Some claim that the Administration bill's present limits on the number of days of treatment are as generous as practicable, and others even suggest that the limits should be toughened. As noted above, we believe that the opposite is true -- cost containment will be achieved by removing artificial treatment limits -- and evidence is emerging to substantiate this position.

The National Advisory Mental Health Council has demonstrated that short-term expenditures for mental health benefits without artificial limits will reduce "psychiatric recidivism" and lower long-term costs. In addition, recent information -- such as that presented in testimony by the Hewitt Associates before the Senate Labor Committee on November 8, 1993 -- indicates that a properly managed mental health program with significantly more generous benefits than the Administration's pre-2001 proposal is affordable initially, and need not rely on "long-term savings" to justify its inclusion. The Hewitt study of benefits currently provided by a large number of private health insurance plans indicates that both long-term savings and reasonable initial costs are feasible, even when a generous mental health benefit is available. If the Hewitt data is true for all persons needing mental health services, then certainly we can afford to provide these services without artificial limitations to children beginning in 1997, because the cost effectiveness of treating children is generally much greater than the treatment of adults.

Devereux recognizes the financial dilemma faced by federal lawmakers. Unlimited childhood mental health benefits would cost some federal dollars initially, while the costs of untreated children appear to be visited upon local school budgets and state-funded agencies and juvenile or criminal justice systems. However, this federal-state distinction is rapidly disappearing. School-age children with mental illnesses receive partial federal education funding under the IDEA Act. Children from eligible families (or whose eligibility is considered independently of their parents' resources) receive federal Medicaid funds. And with the recent expansion of the federal role in funding local police forces, juvenile treatment programs, and prosecuting and incarcerating persons for certain crimes, the distinction is even becoming blurred in the criminal justice area.

In short, the initial costs of proper mental health services are much more reasonable than some suggest and particularly in the case of children these costs will be more than offset by

substantial savings in other programs at the federal and state levels.

Services for Persons With Developmental Disabilities³

Devereux supports the Administration's new home and community-based, long-term care program. Any additional services that will allow persons with severe cognitive or mental impairments to be well served at home or in the community are welcome and necessary.

Devereux also applauds the Administration for recognizing that not all persons with developmental disabilities will qualify for this new program and thus providing for a continuation of existing Medicaid-based long-term care programs, such as intermediate care facilities for the mentally retarded (ICF/MR). An existing group of Devereux patients depends on ICF/MR funded services which cannot be effectively delivered in the home or community-based environment. In addition, the proposed changes to current Medicaid rules regarding retained assets and income will be of significant assistance to this population.

Devereux's concern with the Administration's proposal relates to the new authority for states to combine the new community-based, long-term care program and existing Medicaid community-based and ICF/MR programs into a "single capped program."⁴ While Devereux believes that the new emphasis on home and community-based care is appropriate in theory, we are concerned that, in practice, some states will misuse this new authority in order to lower costs by eliminating or severely limiting the availability of "institutional" care. While care should be delivered in the least restricting setting, some patients' day-to-day needs call for more structure than home and community-based services can provide. For these patients, services funded through the ICF/MR program are essential. To ensure the appropriate availability of such services, we believe that the states should be given clear guidelines regarding when a person may be denied ICF/MR funded services in any "single capped program."

Consistent with our mental health recommendations, Devereux recommends that children with developmental disabilities be eligible for the same services available in the mental health component of the standard benefits package, without artificial limitations (such as maximum days of inpatient services.) Our recommended approach has the benefit of: 1) eliminating any inequity in treatment between developmentally disabled and seriously emotionally disturbed children, and 2) recognizing the reality of today's treatment programs: many children have multiple diagnoses which blur the line between emotional disturbances and developmental disabilities.

Children with developmental disabilities are also served through IDEA funding and, to a limited extent, through the ICF/MR portion of the Medicaid program. However, there has been a trend in recent years toward greater control of education funds by local school districts. As a result, under the pressure of growing disparities between the special needs of students and funds available for public education, local school districts are beginning to impose artificial, economically-driven restrictions on services for developmentally disabled students. If this trend

³ The most widely accepted definition of this term appears in section 102(7) of the Developmental Disabilities Act of 1984 (Public Law 98-527).

⁴ As described in Section 4213 of the Administration's "Health Security Act."

continues and IDEA funding continues to contract as local school districts exert greater control over it, then a supplement for services to children with developmental disabilities -- already necessary in some states -- will become essential on a national scale. We therefore recommend adding a supplemental benefit for children with developmental disabilities which would provide for such treatment as is determined necessary by medical professionals.

Demonstration Projects

Professionals and clinical researchers have long expressed concern about the lack of data measuring the effectiveness, appropriateness, and comparative cost of many current and newly emerging behavioral health care treatments. A national research agenda with adequate funding to support demonstration projects is sorely needed. Specifically, Devereux recommends the following three initiatives:

- o An Effectiveness Demonstration Initiative. This would support demonstration and research projects that assess which services and programs are most effective and cost efficient for specific disabilities.
- o An Acceptability of Care Demonstration Initiative. We need to examine the acceptability of systems of care to ensure that the recipients of services are satisfied.
- o A Continuum of Care Demonstration Initiative. While many persons with mental illnesses and disabilities can ultimately be successfully served in community programs, Devereux's experience have been that a continuum from most restrictive to least restrictive care is needed. Devereux recommends demonstration and research projects that can be used to evaluate the continuum approach to ensure that children and their families receive appropriate, effective services.

Summary

In summary, our positions regarding the Administrations's health care plan are as follows:

- o Devereux supports the new mental health benefit, but would recommend adding a supplemental benefit for children, providing for such treatment as is medically necessary
- o Devereux supports the new long-term care proposal, but recommends that the optional single capped program contain strict rules prohibiting states from denying medically appropriate ICF/MR services.
- o Devereux recommends adding to the long-term care proposal a supplemental benefit for children with developmental disabilities, providing for such treatment as is medically necessary.
- o Devereux recommends that funding be made available for research and demonstration initiatives to ensure that practitioners and systems of care are effective, accountable, cost efficient, and consistent with the needs and expectations of the people being served.

Thank you again for this opportunity to testify, and please accept our standing offer of assistance to the Committee.

Mr. LEWIS [presiding]. Thank you, Mr. Burd.
Ms. Beall.

**STATEMENT OF MARY ANN BEALL, BOARD MEMBER,
NATIONAL ALLIANCE FOR THE MENTALLY ILL**

Ms. BEALL. Yes, I am Mary Ann Beall, and I would like to thank you for the opportunity to speak today.

I am a board member of the National Alliance for the Mentally Ill, with an organization that has 140,000 members. I am here to speak on behalf of those who, like me, suffer from long-term chronic mental illness, and their families.

I suffer from severe anxiety, obsessive compulsive disorder and depression. Because of my disorders, it is very difficult for me to be here today, and to be speaking to you. However, the issues before you are of such gravity, such critical concern to people like me, that I simply could not stay away. The decisions that you and others like you will be making in the process of national health care reform can mean life and death to people like me, the very stuff of which our hopes and our lives are made.

Excuse me, I am finding this difficult. I ask for your patience.

Mr. LEWIS. Take your time.

Ms. BEALL. Major mental illnesses such as schizophrenia, manic depression, major depression, obsessive compulsive disorders, and the panic and anxieties disorders, are neurobiological disorders of the brain. They respond to medical treatment at a far higher rate than many classical medical conditions.

These are lifelong disabling conditions. We are learning how to treat them effectively. We do not yet know how to cure them. In this, they are like many other chronic disabling conditions like M.S., the various autoimmune disorders, lupus, and so forth. Because you cannot see the wheelchair in my head doesn't make my mental illness any less severe or less disabling.

The result of my not having a visible disability is that through inadvertency or perhaps through lack of information, I and people like me risk being overlooked or having the full range of services and supports that we need not included in national health care reform. Without them, people like me cannot even hope to live and work in our home communities or have any chance for decent quality of life.

You would not deny access for a mobility impaired person to a wheelchair and other appropriate and effective technological and medical interventions that would restore their function. And I ask you for no less than that for people like me.

Severe mental illnesses wax and wane, and over time both the acuity and the kind of symptoms that people like me experience can vary widely over the course of the illness. The support service or treatment which I respond to very well at one time in my life may be completely ineffective at another time. This is why we need a wide range of services.

People like me need not only medication, medication management and monitoring, but also a full array of effective community supports, as well as case management to coordinate our care.

Right now, people like me are doing very poorly in HMOs and in care systems that restrict access to treatment. As a matter of

fact, I know within the last 3 months of several deaths that have taken place because people have been denied care or care has been rationed to them.

These are systems that are structured really to provide acute care, and I am afraid that the Clinton proposal also tends to be focused in that direction. These simply do not work for people like me with chronic disabling conditions.

What is agonizing to me right now is that there have been so many recent advances in treatment for people like me, medications and support that really have the capability to bring us back into life and into being productive citizens. We live at a time of great promise, and yet we are also facing a moment in time when because of the lack of knowledge about recent advances in the field, and perhaps because of the stigma of mental illness itself, access for us to those so necessary services may be curtailed. And people like me, millions of us, may find ourselves effectively abandoned, written out of health care reform. Or worse yet, ghettoized in a permanent state of second-class citizenship with limited access to the services that we need. And this is what I am here today asking you to prevent.

We need not just good doctors and access to medications and the laboratory tests to monitor the safety of our medications, but we also need skill development, psychosocial rehabilitation, and case management. Currently, many of us receive precisely these services through Medicaid, and we need them to be included in national health care reform. If they are not included, it will be catastrophic.

I speak now for the many people in my home State who are currently in day treatment programs and social programs. There is a great deal of fear in the community among us right now because the Clinton plan would so limit our access to day support programs that many of us, particularly the most severely affected, need to survive in the community.

I think the end result of limiting access to services may be that we will end up using more expensive resources because we will need to be far heavier users of expensive resources such as expensive and intensive inpatient services or residential services, or we will be increasingly transferred into the correction system.

One of the things that we are looking at today are the number of people with long-term chronic mental illness who basically are criminalized because their illnesses are not well treated. I am here to say to you that neurobiologically based disorders of the brain should in all justice be treated exactly as the disorders of any other organ in the human body.

I need to say to you that today as I speak to you, there are millions of fragile disabled people who fear that you will cut our access to the services that make our lives possible. I beg you, these are serious disorders, so serious that if we can't access appropriate treatments, for the most affected these disorders can be terminal. They are life-threatening. Please, I ask you to give us equal consideration with all other people who have medically based disorders.

Thank you.

[The prepared statement follows:]



PREPARED TESTIMONY OF MARY ANN BEALL
CURRENT BOARD MEMBER
OF THE
NATIONAL ALLIANCE FOR THE MENTALLY ILL
AND
A VICE CHAIR OF THE VIRGINIA MENTAL HEALTH CONSUMERS' ASSOCIATION
BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

November 15, 1993
10:00 A.M.
1100 Longworth House Office Bldg.
Washington, D.C. 20515

Mr. Chairman, distinguished Members of the Subcommittee, thank you for the opportunity to address you today at this hopeful and historic time for American's Health Care Systems. I am Mary Ann Beall, a current board member of the National Alliance for the Mentally Ill (NAMI), and vice-chair of the Virginia Mental Health Consumers' Association.

NAMI is a self-help organization of families of persons of all ages with severe mental illness and of those persons themselves. We know better than anyone the emotional suffering and financial collapse that accompany these devastating brain diseases. NAMI's membership totals 140,000 persons nationwide, including in all of the Subcommittee Members' districts. Our organizational structure consists of a 15-member elected volunteer Board, a national office in Arlington, Virginia; 50 state offices; and nearly 1000 local affiliates.

NAMI advocates for persons who have a severe and persistent neuro-biological disorder of the brain, which requires medical care, prescription medication(s), psychosocial rehabilitation, occasional hospitalization, and crisis services. Such persons, like those with diabetes, rheumatoid arthritis, multiple sclerosis -- may well require monitoring, medication, and rehabilitative services on a lifelong basis. I am such a person.

Discrimination against mental illness in current health insurance.

Private health insurance has failed us in many well-known ways: arbitrary "amount, duration, and scope" limits that bear no relationship to what is medically necessary and to what works clinically; exclusion or unaffordable premium after having been ill once; and very low annual and lifetime dollar limits compared with other illness diagnoses. This may be because under the heading "nervous/mental" private insurance mixes together the non-medical treatment of non-life-threatening problems, with medical diagnosis and clinically appropriate medical treatment of the severe and persistent illnesses of the brain. The President's bill will reform health insurance deficiencies, and do it for all Americans. But even the insurance reforms will be not as extensive for us. We alone will have co-payments that are not counted toward annual out-of-pocket limits.

Schizophrenia, manic depression, clinical depression, obsessive/compulsive disorder, and panic disorder -- these are biological disorders of the brain, not outcomes of character fault or bad parenting. They respond well to medical treatment. Agreement on diagnosis, and efficacy of treatment, are measured at higher percentages than for other illnesses. We know how to treat them: what works, what doesn't. Because the condition may be lifelong, and because the treatments that work are frequent and intensive, almost all of the persons for whom NAMI advocates are heavy users of services. This is, of course, another reason we are unattractive to health insurers.

Not coincidentally, failure to furnish third-party coverage for the array of services that helps me be here to talk with you produces sicker people and still greater costs to society, in both the private and public sectors.

Services that work, and services that are covered in the Health Security Act.

Mr. Chairman, distinguished members of the panel, your inquiry in this hearing is about benefits and schedules of covered services. Traditionally, physicians' services, hospital services, laboratory services, prescription medications, rehabilitative services, and nursing facility/community-based care have been the core services covered in third-party plans. Services for persons with severe and persistent

mental illness are generally within these usual classifications. The specifics, the definitions, and the duration are the variants.

Covered services for mental and addictive disorders in the legislative version of the Health Security Act include: "Inpatient services, Intensive nonresidential treatment services, and Outpatient services." NAMI is gratified that the mental illness services are a central, mainstream component of the proposed reformed system, *and* that coverage of an essential component of successful treatment, *prescription medications*, is also included.

We are also appreciative of the inclusion of the intensive nonresidential treatment services in the reformed system. The text of section 1115, subpart d)(2)(A)(iii & iv), of Title I indicates that the Administration understands and accepts the reality that persons with these illnesses can have function restored and that they need skills development and support services to achieve maximum functioning in the community. The Health Security Act explicitly lists pursuit of these treatment objectives as an acceptable criterion for expenditure of plan resources. Thank you, Mrs. Gore and Mrs. Clinton.

Unfortunately when the actuaries began to price such a benefit, they pegged it as too expensive for inclusion in a vehicle that could get the votes for passage. I can't convey to you how sad that makes me. Washington finally got it, but won't go for it. I guess we aren't judged politically important enough. We understand that if no plan passes, there will be no mental illness schedule of benefits to complain about. We also know that no other diagnostic group will have to look around and see that everyone else is treated better than they. That hurts!

Rather than assume that all the others will remain open-ended, and third-party coverage of our diseases will continue to be severely curtailed, why not scale back across the board -- on heart, kidney, lung, liver, musculo-skeletal -- and cover brain disorders on a par with the rest? If persons with severe and persistent disorders of the brain are not treated equally with other illness/trauma diagnoses either in the insurance reforms or in the amount, duration, and scope of covered services -- this isn't reform, and shouldn't be called reform.

NAMI believes the initial 60-day hospital benefit was insufficient. Certainly, given an early diagnosis, and good response to medication, most persons would not use anywhere near 60 days in a year. But NAMI's position is that for the few that need them, days in excess of 60 should be available. For the *outlier* cardiac or pulmonary case, the plan doesn't say "out of here to the public system on the 61st day". It does say this for the person with severe and persistent disorders of the brain.

Psychotherapy will not keep seriously and persistently ill persons out of the hospital. Medication, medical management, psychiatric rehabilitation, case management -- these keep persons like me out of hospitals. Psychotherapy is helpful and appropriate for some persons with serious and persistent brain disorders. But, by itself, without medication and rehabilitation, it cannot prevent relapse. Creating a system in which a hospital safety net may be completely traded away for outpatient psychotherapy visits, especially for children before they have been diagnosed, forces families to gamble while they are hoping against hope to avoid hospitalization.

There are some difficulties with the clinical flow of the mental and addictive disorder schedule of benefits in the Health Security Plan. Generally the inclusion are comprehensive, but the eligibility criteria intended to deter inappropriate usage were not drafted by clinicians. For instance, services are for those who have been ill in the past year. If I just got sick for the first time, I guess that's within the past year. Crisis services, assessment, and diagnosis are not so restricted. This *must* mean that if you're diagnosed, you can be hospitalized -- even if you haven't had the disease during the preceding year -- but the legislative language must be clearer.

How long one can remain in the hospital is dependent on whether they are a danger to their own life or to another's. This criterion allows them to remain past 30 days which otherwise is the limit for an episode. Particularly in the case of children this is an inappropriate threshold.

When one is discharged from the hospital, NAMI knows that their healing is best maintained by their participation in a program that will build or rebuild their community living skills and their ability to relate to others. The plan *requires* that they exchange inpatient days, on a 1 for 2 basis, to access this service (called "intensive nonresidential treatment services"). 120 days of such services are described in the plan, but they are "optional" to the "approved health plan" (AHP). Earlier they had been characterized as part of the national minimum standard benefit. What if a person with mental illness has used all their hospital days for that plan year, and has nothing left to exchange? What if they have a second episode in that plan year and require rehospitalization, but have traded away all their hospital days?

Services that we have now in many states might actually be lost.

The Health Security Act does not cover until the year 2001 a comprehensive, flexible, managed benefit without arbitrary limits -- all the services I and others like me need. Between now and then arbitrary limits, that bear no relationship to medical necessity and to which no other illness/trauma diagnosis is subject, are integral to the plan. While we believe the President's intentions and

commitment to the 2001 end goal, we also feel deeply the implied discrimination between now and then. And, truth be told, we aren't so confident that with four Congressional and two Presidential elections between now and 2001, we really will get full parity then despite everyone's acknowledged good intentions and good will now.

In the seven years until 2001, services people like me get through their state mental health agencies, and their state Medicaid programs, may well be eroded irreparably. The President's coordinator for Health Reform, Mr. Magaziner, has stated often in public settings that the White House doesn't want any person dependent on public programs to have less in the reformed system than he or she has now. Once again, we accept their good faith. But we believe as well that the economic and political pressures on Medicaid may overtake the White House's intention.

Services for persons with serious and persistent brain disorders that accompany and complement diagnostic, medication, and medical management services: case management, psychosocial rehabilitation, home and community-based waivers -- *without* arbitrary limits as in the Health Security Act, are optional in Medicaid under current law. It is the Administration's intention that they will *remain optional* in Medicaid under reform legislation. People like me will need to obtain services through these "options" after our yearly limits in the reformed plan will have been reached. In other words, we need them as supplements to the reformed plan until 2001.

It's a great disappointment that all I need and use won't be *in the reformed system*, rather than split between the reformed system and a "residual" public system. But after the disappointment we still have a serious question. Given that there may be a split system, can we count on such supplemental services being available in the "residual" public system for the next seven years: two years leading up to implementation, two years transitioning, and three years under a system that *mandates* fifty different integrations of existing state public mental health systems with (but not necessarily into) the reformed system. In short, could we wind up worse off under reform than we are under the current public system? This is becoming a rampant fear among consumers.

Benefits originally proposed are already being cut.

Coverage for persons with serious and persistent brain disorders is already being cut back severely from the President's September draft plan. That edition had 60 days/year of inpatient, 120 days/year of intensive nonresidential treatment services, case management, and 30 outpatient psychotherapy visits. All were to be part of the minimum mandated benefit which was to be provided through *all* purchasing alliance/AHP contracts nationwide.

When the legislative language version appeared, 30 of the hospital days had to be exchanged for the first 60 days of intensive nonresidential treatment. But intensive nonresidential treatment had also become *an option at the "approved health plan" (AHP) level*, as did case management. Out-patient psycho-therapy could be extended beyond the 30-day limit if the AHP approved, "as an alternative to hospitalization", but 1 bed day would have to be exchanged for each 4 visits.

Conclusion and recommendation.

Please, Mr. Chairman and distinguished Members of the Committee, follow the knowledge base with your legislation. The science which the Congress has supported over the past generation has dramatically changed our understanding of the severe and persistent illnesses: schizophrenia, manic depression, clinical depression, panic disorder, and obsessive/compulsive disorder. These are neurobiologically based disorders of the brain, not behavior problems or environmentally induced. Abuse or bereavement will not eventually slip into schizophrenia. Congress' own Office of Technology Assessment report, *The Biology of Mental Disorders* (OTA-BA-538, September, 1992) affirms this.

Consequently, NAMI's position is that **NEUROBIOLOGICALLY BASED DISORDERS OF THE BRAIN MUST, IN FAIRNESS AND JUSTICE, BE TREATED EXACTLY AS DISORDERS OF ANY OTHER ORGAN IN THE HUMAN BODY**. Amount, duration, and scope of coverage must have parity across illness/trauma diagnoses. Such treatment is affordable because we know what works and how much. Not including it will be far more costly. Jeopardizing what works for us now, without adequate replacement would be unconscionable.

Mr. LEWIS. Thank you, Ms. Beall, for your moving testimony. You can tell that I lost my voice over the weekend, and I won't be asking any questions. I think it is somewhat appropriate and fitting for a sick member to come and chair the Subcommittee on Health. So you may go. Thank you very much.

The next panel. Thank you for being here.

Mr. Mahoney, do you want to lead off, sir?

STATEMENT OF JOHN J. MAHONEY, PRESIDENT, NATIONAL HOSPICE ORGANIZATION

Mr. MAHONEY. Certainly. Thank you.

On behalf of the National Hospice Organization and the almost quarter of a million terminally ill patients and their families served each year by its 1,500 members, I would like to thank the subcommittee for inviting NHO to testify today regarding hospice issues in the context of the President's health care reform proposal.

In past appearances before the subcommittee, the members have repeatedly expressed an understanding of and support for hospice, beginning with the subcommittee's role in the establishment of the Medicare hospice benefit in 1982. Therefore, I will not repeat general background information about hospice here.

There are, however, a few fundamental aspects of hospice, an understanding of which are critical when considering hospice in the context of health care reform. First, hospice care is like virtually no other type of health care. Its goals are not curative, but palliative. Nevertheless, hospice care involves highly sophisticated physician and nursing services, particularly in the specialized area of pain and symptom management. It is primarily home care, but it may include inpatient care. Hospice care is acute care, not long-term care.

Second, hospice is a pioneer in the use of case management. Case management, performed by the hospice interdisciplinary team, is an essential feature of hospice care.

Third, hospice providers have experience in delivering quality services in a cost-effective manner. Since the inception of the Medicare hospice benefit, hospice providers have always been placed at risk financially to provide quality care within a budget and they have successfully met this challenge while lowering overall costs.

Obviously, NHO is extremely pleased that hospice care is included in President Clinton's proposal. Importantly, hospice care is defined in the legislation as the Medicare hospice benefits package of services. This definition of hospice care is essential to ensure that there is a uniform understanding about what constitutes hospice care.

However, it appears that the administration intends in general that provider qualifications be established at the State level, either through a licensure process or through the development of a new certification process. While this may be appropriate for other types of health care providers which have long been subject to State licensure, NHO is concerned about using this approach for hospice.

Faced with a multitude of tasks to implement health care reform, some States, not all of which currently license hospices, may not adequately focus on qualifying requirements for hospice providers which will obviously be only one small piece of a very large pie.

NHO has already confronted this issue in Tennessee, where health care reform efforts are currently under way.

In order to avoid this foreseeable problem, NHO urges that any health care reform plan require that hospices meet standards at least as stringent as the Medicare conditions of participation in order to provide hospice services as part of the health plan.

Finally, as the subcommittee knows, in order to finance certain portions of the Health Security Act, significant Medicare cuts are proposed. Currently, increased premiums to be paid by beneficiaries and reductions in hospital payments are slated to bear the bulk of the cuts.

NHO is concerned generally that the Medicare program is the target of such substantial savings in the proposed plan. We believe there are limits beyond which reductions in payments under the Medicare program cannot be made without jeopardizing the program itself.

During the past 15 years, hospices have had an important impact on the delivery of health care to terminally ill Americans. Health care reform seeks to ensure access to quality health care services while containing costs. Existing hospice providers in large part currently are achieving these goals.

In crafting a health care reform package, NHO asks that the subcommittee and the Congress not forget hospice and not disadvantage those providers which are already contributing to the solution.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF JOHN J. MAHONEY
PRESIDENT
NATIONAL HOSPICE ORGANIZATION**

NATIONAL HOSPICE ORGANIZATION

On behalf of the National Hospice Organization (NHO), its members and the terminally ill patients and their families served by those hospices, I would like to thank the Subcommittee for inviting NHO to testify today regarding hospice issues in the context of the President's health care reform proposal.

The NHO, headquartered in Arlington, Virginia, is the only national non-profit membership organization devoted exclusively to hospice in the United States. Since 1978, it has worked to meet the needs of the terminally ill and promote the philosophy of hospice care. I have been the CEO of NHO since October, 1984, and prior to that time, I was the Executive Director of a hospice in Boulder, Colorado.

NHO's members include more than 1,500 provider members (local hospices) in all 50 states and approximately 2,500 individual professional members. Forty-six states have developed state hospice organizations, who are also members of NHO.

NHO represents the interests of the terminally ill and hospice care to the Congress, government agencies, the courts, other national organizations, and the public. Among the issues it has addressed are standards criteria, licensure, patient self-determination, reimbursement, ethical practices of hospice care, and hospice's opposition to euthanasia and physician-assisted suicide. Virtually all of these issues are implicated in the President's health care reform proposal, and NHO appreciates the opportunity to share its views on hospice and health care reform.

HOSPICE IN BRIEF

In previous testimony before the Subcommittee, NHO has provided detailed information about the philosophy of hospice, the design of the Medicare hospice benefit, and the cost-effectiveness of hospice care. Moreover, this Subcommittee has repeatedly expressed an understanding of and support for hospice, beginning with its instrumental role in the establishment of the Medicare hospice benefit in 1982. Therefore, NHO will not repeat general background information about hospice here.

There are, however, a few fundamental aspects of hospice, an understanding of which are critical when considering hospice in the context of health care reform:

1. **Hospice care is like virtually no other type of health care.** Its goals are not curative but palliative. Nevertheless, hospice care involves highly sophisticated physician and nursing services, particularly in the specialized area of pain and symptom management. It is primarily home care, but it may include inpatient care. Hospice care is **acute care**, not long-term care.
2. **Hospice treats not only the physical needs of the terminally ill patient but also the patient's related psychological and spiritual needs in a coordinated way.** Moreover, in meeting these multiple needs, hospice care is more than the sum of its parts. The work of the hospice professionals (physicians, nurses, social workers, counselors, home health aids, therapists, volunteers) is highly integrated, with each contributing to a single goal -- the well-being of the terminally ill patient in his or her last days of life.
3. **Hospice is ahead of the curve in its use of case management.** Case management performed by the hospice interdisciplinary team is an essential feature of hospice care. As the Subcommittee knows, hospice care is a

comprehensive set of services which are available, as needed, for each individual hospice patient. Case management is critical to ensure that each patient receives the appropriate mix of services and that the mix changes as patient needs change.

4. Hospice providers have experience in delivering quality services in a **cost-effective** manner. Since the inception of the Medicare hospice benefit, Medicare has employed a per diem prospective payment methodology for hospice care. Thus, hospice providers have always been placed at risk financially to provide quality care within a budget, and they have successfully met this challenge. Studies suggest that hospice care substitutes home care for hospitalization, lowering overall costs.

5. Hospice care extends beyond the terminally ill individual and includes the patient's family and loved ones in the unit of care. Family members and loved ones receive attention during the care of the patient, and **bereavement care** is critical to supporting surviving family members and friends.

These fundamental aspects of hospice demonstrate the unique nature of hospice care in the health care sector. It cuts across many types of health care and yet does not fit neatly into any single category. Because hospice is relatively new and accounts for a relatively small portion of health care expenditures, NHO is concerned that the details of how hospice will fit into a health care reform package may inadvertently be given inadequate consideration. The remainder of NHO's testimony focuses on hospice in the context of President Clinton's proposed Health Security Act.

HOSPICE AND THE CLINTON HEALTH SECURITY ACT

Hospice in the Comprehensive Benefits Package

NHO is extremely pleased that hospice care is included in President Clinton's proposed comprehensive benefits package. Importantly, hospice care is defined in the legislation as the Medicare hospice benefit's package of services. This definition of hospice care is essential to ensure that there is a uniform understanding about what constitutes hospice care.

Qualifications for Providers of Hospice Care

It appears that the Administration intends, in general, that provider qualifications be established at the state level either through a licensure process or through the development of a new certification process. While this may be appropriate for other types of health care providers which have long been subject to state licensure, NHO is concerned about using this approach for hospice.

Most importantly, not all states currently license hospice providers. NHO is actively encouraging state hospice organizations in those states without licensure to push for hospice licensure now. Nevertheless, it is unlikely that all states will have enacted hospice licensure before implementation of health care reform. Then, faced with a multitude of tasks to implement health care reform, states may not adequately focus on qualifying requirements for hospice providers which will be one small piece of a very large pie.

NHO already has some experience with this issue at the state level where health care reform efforts already are underway. The TennCare Medicaid waiver request submitted by the state of Tennessee to the Health Care Financing Administration (HCFA) provides a current example for our concerns. Tennessee is a state without licensure for home-based hospice. While the state included hospice on the list of covered services for its health care reform plan, it apparently inadvertently did not consider who would be qualified to provide hospice care

absent state licensure. Through the efforts of NHO and the Tennessee Hospice Organization which brought this problem to the attention of HCFA and the state of Tennessee, it is our understanding that the state will require hospice providers which participate in the program to be Medicare-certified.

While this could be considered merely one micro-issue lost in a myriad of macro-issues, terminally ill patients who wish to receive hospice care should be assured that only entities qualified to provide hospice care will be allowed to do so. In order to avoid this foreseeable problem, NHO urges that any health care reform plan require that hospices meet standards at least as stringent as the Medicare conditions of participation in order to provide hospice services as part of a health plan.

The Medicare hospice benefit has been the common denominator in standard setting for hospice providers. An expanded use of Medicare conditions of participation would be appropriate for hospice and would help to ensure consistency in the provision of hospice care across states to Medicare and non-Medicare terminally ill patients alike.

Although the Clinton draft bill does not require that hospice services be provided by a Medicare-certified hospice program, § 1117 of the bill regarding coverage of hospice care, as defined by Medicare, also references Medicare's definition of "hospice program". We are encouraged by the inclusion of this reference and would like to see this provision clarified to confirm that entities wishing to provide hospice care will have to meet the Medicare requirements for a hospice program.

Hospice and the Long-Term Care Provisions

As discussed above, hospice is an acute care benefit and is appropriately included in the plan's comprehensive benefit package. The hospice benefit, as designed by Medicare, assumes that, in addition to hospice services, a terminally ill hospice patient at home generally also will have a primary caregiver who provides supportive services. Not all hospice patients are fortunate enough to have a family member or friend willing or able to perform informally the primary caregiver role. Currently, Medicaid-eligible hospice patients are sometimes able to receive Medicaid-covered attendant care services which serve as a substitute primary caregiver.

The President's Health Security Act, as currently drafted, would establish a new state-administered non-age-based and non-means-tested home and community-based long-term care program for individuals who need assistance with three or more activities of daily living and who are expected to require such assistance for at least 100 days. Under the program, there would be mandatory coverage of personal assistance services, and states would be able to offer a wide range of additional long-term care services, such as homemaker services.

In addition to the President's new home and community-based program, it appears that Medicaid will continue to cover a variety of home and community-based long-term care services for both the categorically and medically needy. As is currently the case, Medicaid eligible hospice patients may be able to obtain attendant care-type services through the proposed Medicaid program.

As the legislative process continues to refine these proposals, NHO hopes that access by hospice patients to these services will be confirmed and clarified.

Medicare Cuts

In order to finance certain portions of the Health Security Act, significant Medicare cuts are proposed. Currently, increased premiums to be paid by beneficiaries and reductions in hospital payments are slated to bear the bulk of the cuts.

NHO is concerned generally that the Medicare program is the target of such substantial "savings" in the proposed plan. There are limits beyond which reductions in payments under the Medicare program cannot be made without jeopardizing the program itself.

NHO also is concerned that Medicare-certified hospices specifically could be asked to bear additional reductions in the rate of increase in their Medicare payments. Under Medicare's per diem prospective payment system for hospice, providers already are at risk financially to provide the full range of hospice services, as needed, to each Medicare hospice patient. In addition, because of differences between hospices and other providers, hospices are less able to bear a cut in their Medicare reimbursement. For example, a large percentage of hospice patients are Medicare/Medicaid eligible, and a smaller number are "private pay" patients. Thus, unlike many other providers, hospices have limited ability to offset any Medicare losses.

Moreover, unlike a reduction or freeze in the Medicare cost limits for other providers which affects only that portion of those providers with costs at or above the limits, a reduction in Medicare reimbursement for hospices would affect each and every Medicare hospice provider. Therefore, many hospice programs would likely have difficulty surviving if Medicare payments rose more slowly than their costs over an extended period of time.

CONCLUSION

During the past 15 years, hospices have had an important impact on the delivery of health care to terminally ill Americans. Health care reform seeks to ensure access to quality health care services while containing costs. Existing hospice providers, in large part, currently are achieving these goals. Hospice, while a small part of the overall health care system, meets a critical need of the terminally ill and must not be inadvertently overlooked. In crafting a health care reform package, NHO asks that the Subcommittee and the Congress not forget hospice and not disadvantage those providers which already are contributing to the solution.

The National Hospice Organization thanks the Subcommittee for this opportunity to make our views known.

Mr. LEWIS. Thank you, Mr. Mahoney.
Ms. Raymond.

**STATEMENT OF SANDRA C. RAYMOND, EXECUTIVE DIRECTOR,
NATIONAL OSTEOPOROSIS FOUNDATION**

Ms. RAYMOND. Thank you, Mr. Chairman.

My name is Sandra Raymond and I am the founding executive director of the National Osteoporosis Foundation.

As you may know, osteoporosis is a silent bone-thinning disease which affects 25 million Americans. Eighty percent of those affected by osteoporosis are women, which is why osteoporosis stands as one of the three leading diseases of women. One in two women and one in five men will develop fractures due to osteoporosis, typically fractures of the hip and spine.

It is a little known fact that a woman's risk of developing a hip fracture is equal to the combined risk of developing breast, uterine, and ovarian cancer. In the 1990s, osteoporosis will result in 2.5 million hip fractures and 5 million vertebral fractures, causing pain, disability, deformity, loss of independence, and death. In fact, in the 1990s, 375,000 individuals will die due to complications resulting from these fractures.

The direct and indirect costs of osteoporosis in the U.S. in 1992 were \$10 billion. However, if we don't stop it now, these costs are expected to rise to \$60 billion by the year 2000, and \$200 billion by the year 2040. Osteoporosis is a model for health care cost containment. The health care reform movement can begin to stem the tide of this national tragedy.

While we cannot yet replace bone once it has been lost, osteoporosis is an essentially preventable and treatable disease. We presently have the means to greatly reduce the human and economic toll of osteoporosis.

The basic benefits package of a national health plan which strives to prevent disease before its onset must address osteoporosis. We now have safe, reliable, effective, accurate tests to measure bone mass. These noninvasive tests detect low bone mass and accurately predict the risk of future fractures. These tests are even more predictive of a catastrophic event such as hip fracture than the blood pressure and cholesterol tests used to ascertain the risk of cardiovascular disease and stroke.

A basic benefits package which includes early detection, treatment and management of patients with osteoporosis, and osteoporotic fractures, must include reimbursement for bone mass measurement tests and coverage for emerging biochemical tests to determine high-risk populations, physician's visits, medications, inpatient and outpatient rehabilitation services, and long-term care.

The lead institute of the National Institutes of Health, NIAMS, the National Institute for Arthritis and Musculoskeletal and Skin Diseases, which has the responsibility for osteoporosis research, has never ever received parity with the other institutes of health. Outstanding peer reviewed research grants in osteoporosis are not currently being funded due to the extremely low pay line of this institute.

I believe the institute's pay line is 12 percent, as compared to all of NIH, all of the institutes, which are at about 25 to 26 percent.

While the NIH Revitalization Act of 1993 authorized \$40 million in new funds for osteoporosis research, no new funds for this purpose were appropriated by the Congress in 1994.

In closing, a comprehensive national strategy to address osteoporosis includes a basic biomedical research effort and health policies and programs of insurance coverage for osteoporosis services and certainly a program of public education to alert the American people that this disease is preventable and treatable now.

Thank you.

[The prepared statement follows:]

TESTIMONY SUBMITTED TO THE SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE

BY

SANDRA C. RAYMOND, EXECUTIVE DIRECTOR
NATIONAL OSTEOPOROSIS FOUNDATION
MONDAY, NOVEMBER 15, 1993

Mr. Chairman, my name is Sandra Raymond and I am the founding Executive Director of the National Osteoporosis Foundation. As you know, osteoporosis is a silent, bone-thinning disease which affects 25 million Americans. Eighty percent of those affected by osteoporosis are women, which is why osteoporosis stands as one of the three leading diseases of women. One in two women and one in five men will develop fractures due to osteoporosis, typically fractures of the hip and spine. It is a little known fact that a woman's risk of developing a hip fracture is equal to the combined risk of developing breast, uterine, and ovarian cancer.

In the 1990's, osteoporosis will result in 2.5 million hip and 5 million vertebral fractures causing pain, disability, deformity, loss of independence and death. In fact, 375,000 individuals will die due to complications resulting from these fractures. With hip fracture, the most serious consequence of osteoporosis, at least half of those able to walk before sustaining a hip fracture do not walk independently afterward. Their ability to care for themselves is compromised and their quality of life is reduced. Half of all hip fracture victims experience social deterioration and one-third may be totally dependent. For many women and older men, hip fracture is often the event that precipitates institutionalization.

Vertebral fractures are also disabling since compression of spinal bones cause not only deformity, but also the realignment of the body causing compression of the abdominal organs leading to difficulties in eating and swallowing and an awkward gait which may precipitate a fall leading to other fractures and pain.

Without interventions, the problem of osteoporosis will worsen as the population ages. In 1992, the acute care costs of one hip fracture was \$40,000 and this figure does not include the long-term care costs associated with this catastrophe. The direct and indirect costs of osteoporosis in the U.S. in 1992 were \$10 billion. However, if we don't stop it now, these costs are expected to rise to \$60 billion by the year 2000 and \$200 billion by the year 2040.

Recently, the University of Southern California's Gerontology Center ranked osteoporosis, along with Alzheimer's disease, as potential federal "budget busters." If osteoporosis is not addressed through comprehensive programs of medical research and preventive health strategies, the costs of osteoporosis will swamp any efforts to contain rising health care costs.

Osteoporosis is a model for health care cost containment. The health care reform movement can begin to stem the tide of this national tragedy. While we cannot yet replace bone once it is lost, osteoporosis is an essentially preventable and treatable disease. We presently do have the means to greatly reduce the human and economic toll of osteoporosis.

The basic benefits package of a national health plan which strives to prevent disease before its onset must address osteoporosis. We now have safe, effective, reliable, and accurate tests to measure bone mass. These non-invasive tests can detect low bone mass and accurately predict the risk of future fractures. These tests are even more predictive of a catastrophic event, such as hip fracture, than the blood pressure and cholesterol tests used to ascertain the risk of cardiovascular disease and stroke. A protocol for reimbursement is as follows:

Bone mass measurement tests are recommended to assist physicians in identifying those postmenopausal women and others at risk for osteoporosis in whom discovery of susceptibility is needed to decide upon treatment, and to monitor the effectiveness of that treatment. A single test is performed to define risk and a follow-up test is undertaken after an appropriate interval, e.g., 2 - 5 years, or as medically necessary, to monitor the efficacy of treatment.

A basic benefits package which includes early detection, treatment and management of patients with osteoporosis and osteoporotic fractures must include reimbursement of bone mass measurement tests, physician visits, medications, inpatient and outpatient rehabilitation services, and long-term care.

And, with an expanded federal medical research effort, osteoporosis will be brought under control. The present biomedical research program on osteoporosis is woefully inadequate. The lead Institute of the National Institutes of Health (NIH), the National Institute for Arthritis and Musculoskeletal and Skin Diseases (NIAMS), which has the responsibility for osteoporosis research, has never achieved parity with the other Institutes of Health. Outstanding peer-reviewed research grants on osteoporosis are not being funded due to the extremely low payline of this Institute.

The NIAMS payline for osteoporosis grants is around the 12 percent level whereas the average payline for NIH is 25 to 26 percent. With a reasonable biomedical research effort, experts in the field agree that osteoporosis can be brought under control in the next decade. While the NIH Revitalization Act of 1993 authorized \$40 million in new funds for osteoporosis research, no new funds for this purpose were appropriated by Congress in FY 1994. Current federal spending on osteoporosis research is little more than \$1 per person affected by the disease.

In closing, a comprehensive national strategy to address osteoporosis, which includes a coordinated program of research, health policies, insured coverage for osteoporosis services and a program of public education to alert the American people to the consequences of this silent, devastating disease must be established in FY 1994.

Thank you.

Mr. LEWIS. Thank you, Ms. Raymond.

Mr. Eakes, am I pronouncing your name right?

Mr. EAKES. Eakes.

Mr. LEWIS. Thank you.

**STATEMENT OF M. GAREY EAKES, PAST PRESIDENT,
NATIONAL ACADEMY OF ELDER LAW ATTORNEYS**

Mr. EAKES. Thank you, Mr. Chairman.

Mr. Chairman, my name is M. Garey Eakes. I am a past president of the National Academy of Elder Law Attorneys. We thank you and the subcommittee for holding the hearings and we appreciate the opportunity to testify before you. We also acknowledge the Clinton administration's efforts in proposing the Health Security Act.

Long-term care must be an integral part of health care reform. Our clients experience the painful choices of the current system with its bias toward institutional care and impoverishment.

We strongly support expansion of home and community-based care. Our clients seek options allowing them to receive or provide care at home. The Act should mitigate the bias that forces care givers to give up and place loved ones in a more expensive institutional care setting.

The system must ensure sufficient services to provide realistic alternatives to institutions. The home and community-based care provisions of the act do not have the guarantees as do other sections of the act, and services could prove to be inadequate.

If home and community-based care is subject to Federal budget and appropriations constraints, then it may be an unfulfilled promise. We ask you to ensure that people can count on community-based care.

Long-term care insurance is a likely part of reform. If you expect people to seek such coverage, then you must protect them by passing the long-term care insurance provisions in the act.

Affordability and insurability factors limit the reliance we place on this insurance. People of modest means still remain left out. They cannot rely upon Medicaid and cannot afford insurance. Do not overlook the plight of this group, nor their resentment at being left with no choice other than impoverishment.

We are disappointed the act will not further reform institutional care, which retains impoverishment as the threshold for assistance. Requiring impoverishment perpetuates an invalid distinction that long-term care is different, less worthy of reimbursement than acute care.

The heart disease patient suffers little out-of-pocket cost, while the institutionalized person bears the full cost of care. Middle class people do not understand this distinction. Overwhelmed by illness and loss of autonomy, they ask why they must also suffer financial devastation.

Easing spend-down requirements must be a first step to a system that does not require impoverishment. As an immediate step, we urge you to eliminate the State option to impose income caps as a bar to Medicaid coverage. Income caps set at arbitrary levels unrelated to care costs are grossly unfair.

Quality care is a major concern. If long-term care remains a two-tier system, one for the well off and another for the impoverished, horror stories from the past will reemerge. A two-tier system must not be permitted.

The act does demonstrate commitment to due process, and we support reform which guarantees due process for all claimants.

Mr. Chairman, unless we successfully address long-term care now, the cost of solving the problem will increase. Please make long-term care a high priority in health care reform. The Health Security Act takes important first steps.

We in the National Academy of Elder Law Attorneys pledge our support to developing a comprehensive national policy on long-term care.

Again, we thank you for this opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF M. GAREY EAKES, PAST PRESIDENT OF
THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS
BEFORE THE HEALTH SUBCOMMITTEE OF THE
HOUSE WAYS AND MEANS COMMITTEE, MONDAY, NOVEMBER 15, 1993

Chairman Stark, members of the Subcommittee. My name is M. Garey Eakes. I am an elder law attorney in Arlington, Virginia. I am here today as Past President of The National Academy of Elder Law Attorneys, NAELA, a professional association of attorneys dedicated to improving the availability and delivery of legal services to older persons and advocating their interests.

First, Mr. Chairman, I want to congratulate you and your Subcommittee for holding these hearings. Your long standing commitment to health care reform is well known to NAELA members and older persons throughout the country. We sincerely appreciate the opportunity to testify before this Subcommittee about our experience with long-term care issues. We also acknowledge the hard work by the Clinton Administration in submitting the Health Security Act to Congress, and their successful effort to bring health care reform to the top of the national agenda.

Our experience with clients confirms that long-term care is a primary issue that must be an integral part of comprehensive health care reform. We are hopeful that our clients' experiences will help you craft a policy which will ultimately resolve the dilemma of long-term care facing millions of Americans. All Americans must seize this opportunity to join in developing a comprehensive health care policy that will take our nation forward on strong economic footing with affordable quality care available to all.

We focus our testimony on the long-term care aspects of the Health Security Act, specifically our thoughts on expansion of home and community-based care, regulation of private long-term care insurance, retention of the current Medicaid program for institutional long-term care, impact of resource and income eligibility criteria, and due process protections throughout health care reform.

As you would expect, health care concerns are a part of a wide variety of the legal issues faced by older persons. Our clients experience the painful choices of the current long-term care system. A bias toward institutionalization and impoverishment are its primary features.

We strongly support the expansion of home and community-based long-term care with a fair sliding fee scale based on income as proposed in the Health Security Act. Seventy-five percent of long-term care is delivered by informal caregivers in a home setting. Our clients tell us they seek options allowing them to receive or provide care at home. A meaningful home and community-based care system would mitigate the institutional care bias that forces caregivers to give up and place loved ones in more expensive institutional care. The sliding fee scale approach creates an additional incentive for individuals and their caregivers to stay at home rather than face the impoverishment requirements of current institutional care policy.

To be meaningful, the community-based care system must insure availability of services in sufficient quantity to provide a realistic alternative to institutionalization. We are concerned that the proposal may fall short.

First, the home and community-based care provisions do not have the guarantees as do other aspects of the Act. Second, the scope and duration of services could prove to be inadequate to provide viable alternatives for many people with Alzheimer's and other chronic illnesses.

If the home and community-based care program is subject to the constraints of the federal budget and annual appropriations process then it may be an unfulfilled promise of reform. We ask you to ensure that people can count on community-based care.

Private long-term care insurance is likely to be a part of a reform approach to long-term care. We must recognize, however, that affordability and insurability factors limit the reliance we can place on private insurance for long-term care. Even if the most comprehensive long-term care insurance policies are reasonably priced, many persons who have income and assets above the Medicaid financial eligibility standards still could not afford to buy this coverage. Many others will have health care histories that will make them the next uninsured population we must protect.

If we plan to depend upon private long-term care insurance for those who can afford it, then we must provide potential purchasers with broad coverage, including adequate home and community-based care coverage, understandable policies without hidden and overly restrictive gatekeepers, protection from deceptive sales practices, and assurances that the policies are affordable, offering inflation protection and non-forfeiture provisions. At the very least, the long-term care insurance provisions contained in the Act must be enacted, if you expect more people to look to long-term care insurance and rely upon the coverage promised in the policies.

People of modest means will not be able to afford long-term care insurance. These people currently face the unhappy fact that they must spend all their resources on care unless they transfer their assets and suffer the Medicaid ineligibility periods that result. They are unable to rely upon the Medicaid assistance provided to the impoverished and unable to afford insurance to protect them from the greatest threat to their financial security. Do not overlook the plight of this group, nor their resentment at being left with no choice other than impoverishment.

We are disappointed that the Health Security Act will not further reform institutional long-term care. Facility-based long-term care remains a part of the American health care system for which impoverishment is the threshold to assistance.

Impoverishment before assistance perpetuates an invalid distinction that long-term care is somehow different and less worthy of reimbursement than acute care, the heart disease patient incurring great expense suffers little out of pocket cost while the institutionalized person with Alzheimer's Disease bears the burden of the full cost of care. Middle class people with very modest assets do not understand this distinction. They are overwhelmed by the ravages of debilitating illness and loss of autonomy. They ask why they must also suffer financial devastation.

Easing the Medicaid impoverishment requirements, such as increasing the resource limits from \$2,000.00 to \$12,000.00 is a positive step. It would provide a modest but useful financial reserve and preservation of dignity to people who lose both under the current system. We should commit, however, that this is just the first step toward a system that does not require a person to submit his or her financial statement and spend down to impoverishment before receiving long-term care coverage.

As an immediate step along this path, we again urge the Congress to eliminate the state option under Medicaid to impose income caps as a bar to Medicaid coverage. Income caps in seventeen states prevent people with income as little as a dollar over the state cap from receiving Medicaid coverage of nursing home cost that may be thousands of dollars more. Although flexibility for the states appears to be a key element of the Health Security Act, income caps, set at arbitrary levels unrelated to the cost of health care, are grossly unfair, and discriminate against people by denying coverage to them on the basis of where they happen to live.

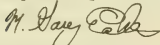
Mr. Chairman, our experience shows that quality of care is a major concern for anyone who seeks long-term care. Commentators have noted that many improvements in the quality of long-term care for Medicaid recipients have come about as a result of easing eligibility criteria to include persons outside the traditional poverty population, persons who expect higher levels of quality and who will tolerate less deviation from decent care. To the extent that long-term care remains a two-tier system, one for the well-off and another for the impoverished, horror stories from the past will re-emerge. No amount of government regulation can prevent the deterioration of a segregated system. A two-tier system must not be permitted.

Another concern we have as professional problem solvers is the mechanism by which disputes in the health care system will be resolved. The Health Security Act demonstrates a commitment to fairness in the design of due process protections for claimants. We regularly see beneficiaries of Medicare and private insurance prematurely forced into Medicaid because they cannot afford to fight the insurance bureaucracy that denies them skilled nursing benefits to which they are entitled. The problem-resolution systems of these programs are designed to sap the energy and resources of a denied claimant rather than make a prompt and fair determination of benefits. We support reform which guarantees due process for claimants throughout the health care system.

In closing, Mr. Chairman, we recognize the cost of long-term care is an increasingly expensive component of our nation's health care cost. It is surely difficult to resolve in the current economic climate. Unless we successfully weave long-term care into the economic fabric of our national health care policy, the dilemma will worsen and the cost of solving it will increase. Now is the time to place long-term care on equal footing with the other pressing issues in health care reform. The Health Security Act takes important first steps in addressing long-term care. We in The National Academy of Elder Law Attorneys pledge our support to the effort to develop a comprehensive national policy for long-term care. Such a policy will serve all of us who face a potential need for long-term care and our collective economic future.

Thank You.

Respectfully submitted,



National Academy of Elder Law Attorneys
By M. Garey Eakes, Esq., Past President

Mr. LEWIS. Thank you very much for your testimony.
Dr. Wellman.

**STATEMENT OF NANCY S. WELLMAN, R.N., R.D., PAST
PRESIDENT, NUTRITION SCREENING INITIATIVE**

Ms. WELLMAN. Chairman Lewis and members of the subcommittee, thank you for the opportunity to testify today on the President's proposal for health care reform.

My name is Dr. Nancy Wellman. I am professor of dietetics and nutrition at Florida International University. I served as president of the American Dietetic Association in 1990.

The American Dietetic Association is a founding partner along with the American Academy of Family Physicians and the National Council on Aging of the Nutrition Screening Initiative. Our goal is to establish routine nutrition screening and intervention to reduce the rate of malnutrition among the elderly and all segments of society.

Older Americans are at disproportionate risk of poor nutrition that can adversely affect their health and vitality. In a recent survey, a national sample of doctors said that one-quarter of their elderly patients suffered from malnutrition. Among hospitalized elderly patients, the rate of malnutrition was even higher. As much as half of this group was estimated to be malnourished.

These high rates of malnutrition should be a giant red flag to health care policymakers, because malnourished older Americans get more infections and diseases, their injuries take longer to heal, surgery on them is riskier, and their hospital stays are longer and more expensive.

Data from case studies collected by 13 States found that early nutrition assessment and intervention saved an average of \$11,000 to \$16,000 per patient. In short, these studies demonstrate that for every dollar spent on nutrition screening and intervention, at least \$3.25 is saved.

President Clinton has taken important steps toward addressing malnutrition in the Health Security Act. Although it is not entirely clear yet, we believe that the basic benefits plan includes coverage of key nutrition therapies and for the first time the services of dietitians and other licensed nutrition professionals.

The President's plan also establishes a schedule of clinician visits for all age groups and includes nutrition counseling in each visit. It also provides for coverage for tube and intravenous feedings where necessary. These nutrition services are crucial to addressing the problem of malnourishment among the elderly and must be included in any health care reform plan passed by Congress.

Today, reimbursement for nutrition services through Medicare and Medicaid is very limited and very sporadic. Nutrition screening and intervention should be routine at admission or enrollment, and for those determined to be at risk, nutrition counseling and therapy should be provided.

Reimbursement for nutrition services by Medicare would permit addressing nutritional problems early, early enough to avoid hospitalization and institutionalization. And it would provide substantial cost savings and an improved quality of life for elderly individuals.

In conclusion, the level of malnutrition among older Americans, is not only unacceptable, it is preventable. We believe we can help keep people out of nursing homes and hospitals, and when they do become ill, we believe we can help them recover faster.

President Clinton's health care reform plan will provide older Americans with the services needed to help them maintain their health and avoid more costly medical treatment. Any health care reform plan that is seriously considered by Congress must include these nutrition services.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF NANCY S. WELLMAN, Ph.D., R.D.
FOR THE NUTRITION SCREENING INITIATIVE
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
NOVEMBER 15, 1993

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today on the President's proposal for health care reform. My name is Dr. Nancy Wellman. I am a professor of dietetics and nutrition at Florida International University. I also served as president of the American Dietetic Association in 1990.

THE NUTRITION SCREENING INITIATIVE

The American Dietetic Association is a founding partner, with the American Academy of Family Physicians and the National Council on the Aging, of the Nutrition Screening Initiative. Our three organizations are joined by a broad, multi-disciplinary coalition of 27 medical, social and aging organizations focusing on the nutrition and health of older Americans. Our goal is to establish routine nutrition screening and intervention to reduce the rate of malnutrition among the elderly and all segments of society.

Older Americans are at disproportionate risk of poor nutrition that can adversely affect their health and vitality. In a survey commissioned by the Nutrition Screening Initiative and reported in the media this spring, a national sample of doctors said that one quarter of their elderly patients suffer from malnutrition. (A copy of the survey, conducted by Peter D. Hart Research Associates, is included with this testimony.) Among hospitalized elderly patients, the rate of malnutrition was even higher -- as much as half of this group was estimated to be malnourished.

These high rates of malnutrition should be a giant red flag to health care policymakers because malnourished older Americans get more infections and diseases, their injuries take longer to heal, surgery on them is riskier and their hospital stays are longer and more expensive.

COST EFFECTIVENESS OF SCREENING AND TREATMENT

For example, randomized, controlled clinical trials have shown that malnourished patients compared to well-nourished patients: take 40% longer to recover from an illness; have two to three times more complications; have hospital stays that are 90% longer and \$5,000 more costly per medical patient and \$10,000 more costly per surgical patient; and are readmitted to hospitals earlier and more frequently.

Data from case studies collected by 13 states found that early nutrition assessment and intervention saved an average of \$11,000 to \$16,000 per patient when provided to those at risk of malnutrition who sought treatment in emergency rooms, outpatient settings, home health agencies, and hospitals. In short, these studies demonstrate that for every dollar spent on nutrition screening and intervention at least \$3.25 is saved.

DETECTING MALNUTRITION

To help address the problem, the Nutrition Screening Initiative has developed and distributed, free of charge, a checklist to help individuals determine if they are at risk of malnutrition. (A copy of the checklist is included with this testimony.) It is a simple self-test that requires individuals to indicate, for example, if they eat fewer than 2 meals per day, how often they eat alone, if they don't have enough money to buy the food they need, and whether they have tooth or mouth problems that make eating difficult, all signs that they may be at risk of malnutrition. This checklist is being distributed to doctors, nurses, and institutions all over the country to promote awareness of the causes of malnutrition. The Nutrition Screening Initiative is also distributing more precise tools for health professionals to use. (These are also included with this testimony.)

THE CLINTON HEALTH CARE REFORM PLAN

But the problem of malnutrition among the elderly requires a response from the government and the health care community. President Clinton has taken important steps toward addressing this in the Health Security Act he sent to Congress recently. Although it is not entirely clear yet, we believe the basic benefits plan includes coverage of key nutrition therapies and, for the first time, the services of dietitians and other licensed nutrition professionals. These services are essential for good nutritional health. The President's plan also establishes a schedule of clinician visits for all age groups and includes nutrition counseling in each visit; and it provides coverage for tube and intravenous feeding where necessary. These services are crucial to addressing the problem of malnourishment among the elderly and must be included in any health care reform plan passed by Congress.

MEDICARE

Today, reimbursement for nutrition services through Medicare and Medicaid is very limited and sporadic. Nutrition screening and intervention should be routine at admission or enrollment and for those at risk, nutrition counseling and therapy should be provided. Reimbursement for nutritional services by Medicare would permit addressing nutritional problems early enough to avoid hospitalization and institutionalization, providing substantial cost savings and an improved quality of life for elderly individuals.

CONCLUSION

The level of malnutrition among America's older adults is not only unacceptable, it is preventable. We believe we can help keep people out of nursing homes and hospitals, and when they do become ill, we can help them recover faster.

Our nation's population is growing older. Without fundamental changes, that group, which now makes up 13% of the population but consumes 36 percent of all health care dollars, will require more health care resources. We must do more to keep older Americans healthy and out of expensive acute and chronic care.

Nutrition screening provides a systematic method to identify those at risk, and to employ the range of social, economic, dietary and medical interventions. Clearly the federal meals programs are some of the most important national interventions available today.

In acute care settings, screening should be a routine part of the admission procedure. Once screened, a nutritional care treatment plan should be developed and implemented as part of the course of treatment. Nursing home patients should be routinely assessed.

President Clinton's health care reform plan will provide older Americans with the services needed to help them maintain their health and avoid more costly medical treatment. Any health reform plan that is seriously considered by Congress must include these nutrition services.

Thank you.

NUTRITION SCREENING AND TREATMENT EXAMPLES OF COST SAVINGS

Nutrition Services

Nutrition services can save costs in a number of ways.

1. Elderly patients with chronic malnutrition often die of infections, most commonly pneumonia and urinary sepsis. Patients who have limited mental or physical ability quickly become dehydrated and dysfunctional. They require time for IV rehydration once hospitalized before their physical abilities can be evaluated. In a study of older patients admitted to a hospital, those who were malnourished had actual hospital charges double that of those who were not malnourished, and their average length of stay was 5.6 days longer than patients without malnutrition. Another study in a Pittsburgh hospital found that the presence of malnutrition resulted in increased variable costs to the hospital of \$9,715 per patient. A third study indicated that costs are four times higher for malnourished patients (\$3,000 compared to \$12,700).
2. On the other hand, adequately nourished patients have decreased morbidity/mortality and fewer secondary medical complications/diseases; wounds heal faster; fewer infections occur; and hospitalizations are shorter. These factors all reduce Medicare/Medicaid and other third-party payer costs. Optimum nutrition care is not only important in the prevention of complications. It is crucial in the progression of other therapies (physical, occupational, speech, etc.) and on the effect of medication on the patient's disease and recovery.

Example 1: A 75 year old man with head and neck cancer worked with a Registered Dietitian during his two month radiation treatment program. Together they had a goal of maintaining his weight and preventing weight loss during the treatments. He actually gained weight during this time and his nutritional status remained stable. He was able to eat a modified diet and utilized nutrition supplements as needed. He was able to have almost continuous treatments since his nutrition status was so good. The typical scenario for most patients undergoing radiation treatments is to lose weight and end up on enteral tube feedings. The initial placement of a feeding tube requires hospitalization none of which was needed in this case.

3. Patients in nursing homes are often malnourished on admission and are frequently on tube feedings that require the nutritional expertise of a Registered Dietitian to determine the balance of nutrients and fluid. In addition, many older Americans are referred for home health care for a lifetime of tube feeding due to dysphagia, confusion, coma, etc. Often, the initial order needs to be adjusted to meet the patient's actual nutrient needs that are coordinated with other aspects of their medical treatment and care.

Example: In 1988 a 61 year old Maryland woman lost 54 pounds in one month. She was referred to several physicians and psychiatrists and even spent one week in a psychiatric unit and yet no one could determine the cause of her problem. Finally a physician diagnosed her as having "pseudo obstruction", a disease that mimics intestinal blockage but is seldom found through routine diagnostic procedures. He started her on an intravenous (parenteral) feeding system that bypassed the digestive tract and her weight and health returned. A Registered Dietitian was called in to do an assessment and found that the patient was able to tolerate a less invasive feeding through a tube inserted into the small intestine. This type of feeding (enteral feeding) is associated with fewer complications and costs \$200-300 per month compared to the parenteral nutrition which costs \$4,000-5,000 per month. This woman will need nutritional assistance for the rest of her life and the change to an enteral feeding will result in a considerable amount of savings.

4. The average cost of treating a pressure sore (decubiti ulcer) is \$15,000. Home health care data show an increase in the number of patients at home with pressure ulcers. Long term care facilities and hospitals also see problems with pressure ulcers when residents are malnourished, especially on admission. Patients with malnutrition on admission to hospitals had more pressure ulcers than those who were not malnourished. Furthermore, those who received nutritional supplementation healed faster than those who did not. The development of pressure ulcers correlates directly with incidence of protein-calorie malnutrition and is one of the practice guidelines being developed by the Agency for Health Care Policy Research.

A recent study found that 70% of all pressure sore patients on oral intake needed additional commercial meal replacements to meet the nutritional requirements for ulcer treatment. Thirty-four percent of all pressure sore patients required enteral or parenteral nutritional support. Ideally, the prevention and treatment of pressure sores should be the joint responsibility of the entire health care team - nursing staff, Registered Dietitian, and physician.

Example: While attending pressure sore rounds in a Philadelphia nursing home, a Registered Dietitian recommended a high protein feeding for a resident with severe (Stage III) ulcers. The wounds healed without further surgical intervention which could have cost up to \$10,000.

5. Older persons with diabetes who receive nutrition services control their diabetes and blood sugars better and have fewer hospital admissions. Nutrition affects the outcome of diabetes mellitus directly through control of body weight, blood glucose, and blood lipid levels (cholesterol and triglyceride) and indirectly by decreasing blood pressure.

Example: A woman in Atlanta with Type II diabetes and elevated cholesterol and triglycerides was treated with oral hypoglycemic agents and lipid lowering drugs, but still had elevated blood glucose. Following four sessions with a Registered Dietitian for nutrition management, the patient lost 25 pounds, her blood glucose and lipid levels were acceptable, and no medication was needed. The nutrition management consisted of a low fat, low cholesterol diabetic diet with emphasis on changing eating habits. The net savings for just one year were \$1,050 (Cost of medications for one year was \$1,200 minus the cost of four Registered Dietitian visits at \$150).

6. Nutrition services are an integral part of medical treatment for renal patients. The provision of nutrition services help delay the progression of the disease and help the patient maintain or improve his/her nutritional status while on dialysis.

Example: A 65 year old male with uncontrolled hypertension and Type II diabetes was referred to a licensed, Registered Dietitian in Atlanta. The nutritional therapy consisted of a diabetic diet with protein, sodium, and potassium restrictions. The nutritional intervention was an attempt to "buy time" before placing the patient on hemodialysis. Following two sessions with the Registered Dietitian, the patient was able to delay dialysis treatments for four months. The cost of the nutrition therapy was \$90 and the cost of the 64 hemodialysis treatments that were avoided cost \$345 per treatment x 14 times a month x 4 months for a total of \$19,320. Nutrition therapy netted a cost savings of \$19,230.

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

DETERMINE YOUR NUTRITIONAL HEALTH

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's —

- 0-2** **Good!** Recheck your nutritional score in 6 months.
- 3-5** **You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.
- 6 or more** **You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

These materials developed and distributed by the Nutrition Screening Initiative, a project of:



AMERICAN ACADEMY
OF FAMILY PHYSICIANS



THE AMERICAN
DIETETIC ASSOCIATION



NATIONAL COUNCIL
ON THE AGING, INC.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the Warning Signs of poor nutritional health.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EEATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/ MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than \$6,000 per year. Having less--or choosing to spend less--than \$25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Level 1 Screen

Body Weight

Measure height to the nearest inch and weight to the nearest pound. Record the values below and mark them on the Body Mass Index (BMI) scale to the right. Then use a straight edge (ruler) to connect the two points and circle the spot where this straight line crosses the center line (body mass index). Record the number below.

Healthy older adults should have a BMI between 24 and 27.

Height (in): _____

Weight (lbs): _____

Body Mass Index: _____
(number from center column)

Check any boxes that are true for the individual:

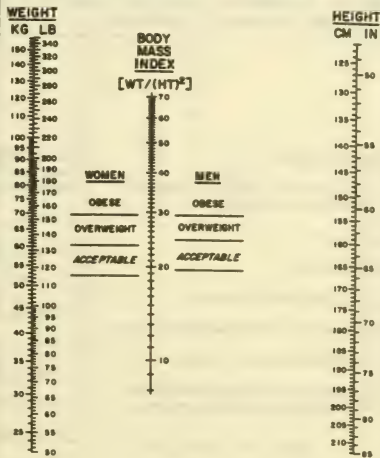
- ☐ Has lost or gained 10 pounds (or more) in the past 6 months.
- ☐ Body mass index <24
- ☐ Body mass index >27

For the remaining sections, please ask the individual which of the statements (if any) is true for him or her and place a check by each that applies.

Eating Habits

- ☐ Does not have enough food to eat each day
- ☐ Usually eats alone
- ☐ Does not eat anything on one or more days each month
- ☐ Has poor appetite
- ☐ Is on a special diet
- ☐ Eats vegetables two or fewer times daily

NOMOGRAM FOR BODY MASS INDEX



LEVEL 1 SCREEN

Name: _____

Date: _____

- ☐ Eats milk or milk products once or not at all daily
- ☐ Eats fruit or drinks fruit juice once or not at all daily
- ☐ Eats breads, cereals, pasta, rice, or other grains five or fewer times daily
- ☐ Has difficulty chewing or swallowing
- ☐ Has more than one alcoholic drink per day (if woman); more than two drinks per day (if man)
- ☐ Has pain in mouth, teeth, or gums

A physician should be contacted if the individual has gained or lost 10 pounds unexpectedly or without intending to during the past 6 months. A physician should also be notified if the individual's body mass index is above 27 or below 24.

Living Environment

- ☐ Lives on an income of less than \$6000 per year (per individual in the household)
- ☐ Lives alone
- ☐ Is housebound
- ☐ Is concerned about home security
- ☐ Lives in a home with inadequate heating or cooling
- ☐ Does not have a stove and/or refrigerator
- ☐ Is unable or prefers not to spend money on food (<\$25-30 per person spent on food each week)

Functional Status

Usually or always needs assistance with (check each that apply):

- ☐ Bathing
- ☐ Dressing
- ☐ Grooming
- ☐ Toileting
- ☐ Eating
- ☐ Walking or moving about
- ☐ Traveling (outside the home)
- ☐ Preparing food
- ☐ Shopping for food or other necessities

If you have checked one or more statements on this screen, the individual you have interviewed may be at risk for poor nutritional status. Please refer this individual to the appropriate health care or social service professional in your area. For example, a dietitian should be contacted for problems with selecting, preparing, or eating a healthy diet, or a dentist if the individual experiences pain or difficulty when chewing or swallowing. Those individuals whose income, lifestyle, or functional status may endanger their nutritional and overall health should be referred to available community services: home-delivered meals, congregate meal programs, transportation services, counseling services (alcohol abuse, depression, bereavement, etc.), home health care agencies, day care programs, etc.

Please repeat this screen at least once each year—sooner if the individual has a major change in his or her health, income, immediate family (e.g., spouse dies), or functional status.

Level II Screen

Complete the following screen by interviewing the patient directly and/or by referring to the patient chart. If you do not routinely perform all of the described tests or ask all of the listed questions, please consider including them but do not be concerned if the entire screen is not completed. Please try to conduct a minimal screen on as many older patients as possible, and please try to collect serial measurements, which are extremely valuable in monitoring nutritional status. Please refer to the manual for additional information.

Anthropometrics

Measure height to the nearest inch and weight to the nearest pound. Record the values below and mark them on the Body Mass Index (BMI) scale to the right. Then use a straight edge (paper, ruler) to connect the two points and circle the spot where this straight line crosses the center line (body mass index). Record the number below; healthy older adults should have a BMI between 24 and 27; check the appropriate box to flag an abnormally high or low value.

Height (in): _____
 Weight (lbs): _____
 Body Mass Index
 (weight/height²): _____

Please place a check by any statement regarding BMI and recent weight loss that is true for the patient.

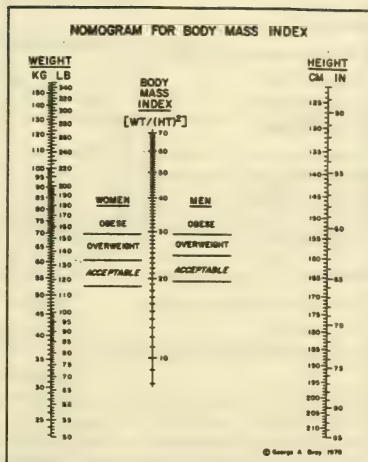
- ☐ Body mass index <24
☐ Body mass index >27
☐ Has lost or gained 10 pounds (or more) of body weight in the past 6 months

Record the measurement of mid-arm circumference to the nearest 0.1 centimeter and of triceps skinfold to the nearest 2 millimeters.

Mid-Arm Circumference (cm): _____
 Triceps Skinfold (mm): _____
 Mid-Arm Muscle Circumference (cm): _____

Refer to the table and check any abnormal values:

- ☐ Mid-arm muscle circumference <10th percentile



- ☐ Triceps skinfold <10th percentile
☐ Triceps skinfold >95th percentile

Note: mid-arm circumference (cm) - (0.314 x triceps skinfold (mm)) = mid-arm muscle circumference (cm)

For the remaining sections, please place a check by any statements that are true for the patient.

Laboratory Data

- ☐ Serum albumin below 3.5 g/dl
☐ Serum cholesterol below 160 mg/dl
☐ Serum cholesterol above 240 mg/dl

Drug Use

- ☐ Three or more prescription drugs, OTC medications, and/or vitamin/mineral supplements daily

LEVEL II SCREEN

Name:

Date:

Clinical Features

Presence of (check each that apply):

- ☐ Problems with mouth, teeth, or gums
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Angular stomatitis
- ☐ Glossitis
- ☐ History of bone pain
- ☐ History of bone fractures
- ☐ Skin changes (dry, loose, nonspecific lesions, edema)

Percentile	Men		Women	
	55-65 y	65-75 y	55-65 y	65-75 y
Arm circumference (cm)				
10th	27.3	26.3	25.7	25.2
50th	31.7	30.7	30.3	29.9
95th	36.9	35.5	38.5	37.3
Arm muscle circumference (cm)				
10th	24.5	23.5	19.6	19.5
50th	27.8	26.8	22.5	22.5
95th	32.0	30.6	28.0	27.9
Triceps skinfold (mm)				
10th	6	6	16	14
50th	11	11	25	24
95th	22	22	38	36

From: Prissach AR. New norms of upper limb fat and muscle areas for assessment of nutritional status. *Am J Clin Nutr* 1981; 34:2540-2545. © 1981 American Society for Clinical Nutrition.

Eating Habits

- ☐ Does not have enough food to eat each day
- ☐ Usually eats alone
- ☐ Does not eat anything on one or more days each month
- ☐ Has poor appetite
- ☐ Is on a special diet
- ☐ Eats vegetables two or fewer times daily
- ☐ Eats milk or milk products once or not at all daily
- ☐ Eats fruit or drinks fruit juice once or not at all daily
- ☐ Eats breads, cereals, pasta, rice, or other grains five or fewer times daily
- ☐ Has more than one alcoholic drink per day (if woman); more than two drinks per day (if man)

Living Environment

- ☐ Lives on an income of less than \$6000 per year (per individual in the household)
- ☐ Lives alone
- ☐ Is housebound
- ☐ Is concerned about home security

- ☐ Lives in a home with inadequate heating or cooling
- ☐ Does not have a stove and/or refrigerator
- ☐ Is unable or prefers not to spend money on food (<\$25-30 per person spent on food each week)

Functional Status

Usually or always needs assistance with (check each that apply):

- ☐ Bathing
- ☐ Dressing
- ☐ Grooming
- ☐ Toileting
- ☐ Eating
- ☐ Walking or moving about
- ☐ Traveling (outside the home)
- ☐ Preparing food
- ☐ Shopping for food or other necessities

Mental/Cognitive Status

- ☐ Clinical evidence of impairment, e.g. Folstein < 26
- ☐ Clinical evidence of depressive illness, e.g. Beck Depression Inventory > 15, Geriatric Depression Scale > 5

Patients in whom you have identified one or more major indicator (see pg 2) of poor nutritional status require immediate medical attention; if minor indicators are found, ensure that they are known to a health professional or to the patient's own physician. Patients who display risk factors (see pg 2) of poor nutritional status should be referred to the appropriate health care or social service professional (dietitian, nurse, dentist, case manager, etc.).

These materials developed by the Nutrition Screening Initiative.

TO: Nutrition Screening Initiative

FROM: Peter D. Hart Research Associates, Inc.

DATE: April 15, 1993

SUBJECT: National Survey on Nutrition Screening and Treatment for the Elderly

Between April 1 and 8, 1993, Peter D. Hart Research Associates conducted a national telephone survey among 757 health care providers and administrators who care for America's elderly population. The survey includes five types of health care professionals who fall into two broad categories and were selected for their familiarity with the health care needs of the elderly: health care providers, including gerontological doctors (132 interviews) and nurses (101), and health care administrators for hospitals (202), nursing homes (217), and home care agencies (105). The Methodological Appendix enumerates the five samples used in this project.

The results from this survey can be summarized in the five following main points:

- ✦ **Malnourishment is a serious problem that affects a substantial proportion of elderly people in the United States. Taken together, gerontological doctors and nurses estimate that one in four of their own patients suffer from malnutrition and that fully one-half of the elderly patients in hospitals are malnourished.**
- ✦ **Doctors and nurses who specialize in geriatrics and the administrators who run America's hospitals, nursing homes, and home care agencies agree that nutrition plays a major role in the prevention, treatment, and recovery from illness and disease.**
- ✦ **Gerontological doctors and nurses and health care administrators widely agree on the cost-effectiveness of routine nutrition screening and treatment for the elderly population.**
- ✦ **One of the biggest obstacles to routine nutrition screening and early nutrition intervention is the lack of reimbursement to health care providers.**
- ✦ **There is broad consensus among those who care for America's elderly population that nutrition screening and treatment should be part of a basic benefits package and should be reimbursed by the government and other third-party payers.**

The consistency of results across all five types of health care professionals provides crucial support for the reliability of these conclusions. Indeed, the similarities in attitudes and perceptions among these groups invariably outweigh the differences in the exact proportions who emphasize the role of nutrition, the extent of malnutrition, and the cost-effectiveness of a program of nutrition screening and treatment.

1. **Malnourishment is a serious problem among America's elderly population.** We turned to doctors, nurses, and administrators who specialize in the care of the elderly to be our "eyes and ears" when it comes to the incidence of malnutrition among the population age 65 and over. After defining "malnourishment" as "a state in which, because of deficiencies, excesses, or imbalances in food or diet, someone is not getting proper nutrients, which weakens his or her body and is harmful to his or her health," gerontological doctors and nurses and health care administrators were asked their perception of the proportion of hospital patients, nursing home residents, home care recipients, and their own patients who are malnourished.

As the following table demonstrates, these gerontological doctors and nurses and health care administrators provide disturbing estimates of the number of elderly Americans suffering from malnourishment. Doctors and nurses who specialize in caring for the elderly estimate that approximately one-half of all elderly hospital patients are malnourished, as are more than two in five nursing home residents.

Table 1: Estimate of the Extent of Malnutrition among Selected Elderly Populations

	Median %
Elderly hospital patients	
Nurses	57
Doctors	43
Hospital administrators	34
Nursing home residents	
Doctors	50
Nurses	38
Nursing home administrators	25
Home care recipients	
Home care administrators	44
Their own patients	
Nurses	28
Doctors	26

Even hospital administrators estimate the proportion of elderly patients in hospitals who are malnourished at one in three; nursing home administrators judge the proportion of malnourished nursing home residents to be one in four; and home care administrators think that more than two in five of the elderly people receiving home care assistance are malnourished.

Most striking is the estimate by gerontological nurses and doctors that more than one in four of *their own patients* are not receiving proper nutrients to such an extent that it is weakening their bodies and harmful to their health.

2. **Doctors, nurses, and health care administrators who care for America's elderly population widely agree that nutrition plays a major role in the prevention, treatment, and recovery from illness and disease.** As the following table illustrates, few of the providers and administrators assign nutrition the most important role in prevention, treatment, and recovery, but these health care professionals do express an extraordinary degree of consensus that nutrition plays a major rather than a minor role in the prevention, treatment, and recovery from illness and disease among the elderly.

Table 2: The Role of Nutrition in Health Care		
	Doctors/ Nurses %	Admin- istrators %
Prevention		
The most important role	15	19
A major role	80	77
A minor role/not much of a role	5	4
Treatment		
The most important role	6	8
A major role	84	80
A minor role/not much of a role	10	11
Promoting recovery		
The most important role	18	12
A major role	80	83
A minor role/not much of a role	2	4

Nutrition's vital role is also illustrated by the importance that health care administrators and providers attach to nutrition screening. Indeed, a majority of hospital and home care administrators, two-thirds of gerontological doctors, and three-fourths of gerontological nurses and nursing home administrators think it is important to ask about diet, eating habits, and weight loss, as well as conducting more intrusive assessments, such as blood tests, blood cholesterol tests, and measurements of body fat, when elderly people are admitted to hospitals, nursing homes, and home care agencies.

Indeed, a majority of gerontological nurses, nursing home administrators, and home care administrators, and a plurality of doctors and hospital administrators believe that more than 90% of elderly hospital patients, nursing home residents, and home care recipients would benefit from routine nutrition screening upon admission. Moreover, similar proportions of gerontological doctors and nurses and health care professionals in this survey believe that four in five of all elderly people in the United States who are living on their own would benefit from periodic nutrition screening and appropriate treatment.

3. **Health care professionals who specialize in geriatrics and the people who run America's hospitals, nursing homes, and home care agencies agree on the cost-effectiveness of routine nutrition screening and treatment, both for their own patients and as part of the health care system for the elderly population in general.** "Cost-effectiveness" was defined in this survey as "the extent to which the savings from fewer illnesses and more complete and rapid recoveries would offset the cost of a nutrition screening and treatment program." As the following table demonstrates, virtually four in five administrators and gerontological doctors and nurses think it would be cost-effective to provide routine nutrition screening and treatment for their patients, and similar proportions believe it would be cost-effective for the health care system in general to provide nutrition screening and treatment for all elderly people in this country. Fewer than one in five believe it would *not* be cost-effective to have a comprehensive program of nutrition screening and treatment for the elderly.

Table 3: The Cost-effectiveness of Nutrition Screening and Treatment

	<u>Admin- istrators</u> %	<u>Doctors/ Nurses</u> %
Routine screening and treatment for their own patients		
Definitely cost-effective	40	49
Probably cost-effective	38	35
Probably not cost-effective	14	9
Definitely not cost-effective	5	2
Routine screening and treatment for all elderly people		
Definitely cost-effective	35	43
Probably cost-effective	45	39
Probably not cost-effective	13	13
Definitely not cost-effective	4	2

The health care professionals in this study were also asked to evaluate the importance of several arguments in favor of conducting nutrition screenings and implementing appropriate and early nutrition intervention for elderly patients under their care. The following table shows that a majority of gerontological doctors and nurses believe that reducing the number and duration of pressure ulcers, reducing complications, and promoting faster wound healing are all *extremely* important reasons for conducting nutrition screening and treatment. A majority of the health care administrators agree with providers when it comes to the beneficial effects of nutrition on pressure ulcers and faster healing, but they also regard the argument that prevention is less costly than treatment as an *extremely* important argument in favor of nutrition screening and early intervention.

Table 4: Assessments of the Importance of Selected Reasons for Conducting Nutrition Screenings and Implementing Nutrition Intervention for Elderly Patients

	<i>Extremely Important Reason</i>	
	<u>Admin-istrators</u> %	<u>Doctors/ Nurses</u> %
Adequately nourished patients tend to have fewer pressure ulcers and to recover from them faster than do malnourished patients	58	68
Adequately nourished patients experience faster wound healing after surgery	53	62
It is significantly less costly to prevent malnutrition than to treat it	53	56
Malnourished patients have three times as many major complications as do adequately nourished patients	49	59
Health care facilities can save thousands of dollars caring for an adequately nourished patient rather than a malnourished patient who recovers more slowly and can develop complications	46	57
Malnourished patients stay in health care facilities two-thirds longer than do adequately nourished patients	44	55

4. One of the biggest obstacles to routine nutrition screening and early intervention is the lack of reimbursement to health care providers. The health care administrators and doctors and nurses in this study were asked to rate how much of a factor six reasons are for why nutrition screenings and early nutrition interventions are not routinely performed. As the following table shows, health care administrators place the most emphasis on the cost and lack of direct reimbursement for nutrition screenings and early intervention, especially those administrators in charge of home care agencies.

Table 5: Reasons Why Nutrition Screenings and Early Intervention Are Not Routinely Performed

	Single Biggest or Major Factor	
	Admin-istrators %	Doctors/ Nurses %
The cost of the procedure and lack of direct reimbursement	62	46
Doctors do not request or emphasize nutrition screenings and treatments	51	55
Most institutions are not informed well enough to follow up properly on the results of nutrition screenings	34	34
A shortage of staff and qualified personnel	31	32
A shortage of registered or licensed dietitians	29	20
There is no proven need for nutrition screenings or scientific evidence of their benefit	17	19

The gerontological doctors and nurses place this reason—the cost of the procedure—second on their list of factors; both the nurses and the doctors themselves assign greater importance to doctors' failure to emphasize nutrition screenings and treatments. Overall, a clear majority of the doctors and nurses and three-fourths or more of the administrators believe that nutrition screening and appropriate treatments for malnourished patients would be routinely performed if the costs were reimbursed.

5. A broad consensus exists among those who care for America's elderly population that nutrition screening and treatment should be part of the basic benefits package included in comprehensive health care reform and should be reimbursed by the government and other third-party payers. As the following table shows, health care professionals in this study overwhelmingly believe that routine nutrition screening and treatment should be reimbursed and that these measures should be part of the emerging package of comprehensive health care reforms.

Table 6: Coverage of Routine Nutrition Screening and Treatment

	Doctors %	Nurses %	Hospital Admin- istrators %	Nursing Home Admin- istrators %	Home Care Admin- istrators %
Should be part of the basic benefits package being developed as part of comprehensive health care reform	74	90	82	86	88
Should be reimbursed by the government or other third-party payers	83	89	88	86	87

This high degree of consensus on the appropriateness of reimbursing nutrition screening and treatment costs, and including these measures in a basic benefits package is entirely consistent with all the other data in this study, which shows the extent to which these health care professionals believe that malnutrition exists among the elderly, understand the importance of nutrition in the prevention, treatment, and recovery from illness and disease, and recognize the cost-effectiveness of nutrition screening and early intervention to treat malnutrition.

Methodological Appendix

This survey consists of the five samples listed in the following table.

Samples Used in the Survey of Health Care Professionals Providing Care for the Elderly Population of the United States		
Type of Respondent	Sample Size	Source of List
Gerontological Doctors	132	Members of the American Geriatric Society engaged in family practice or internal medicine
Gerontological Nurses	101	Members of the National Gerontological Nurses Association
Hospital Administrators	202	SMG Hospital Market Database
Nursing Home Administrators	217	SMG Nursing Home Market Database
Home Care Agency Administrators	105	Home care agency members of the National Association of Home Care

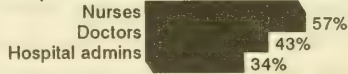
More than 90% of the health care administrators in this survey hold one of the top three positions in the "chain of command" in their institution; more than 80% are among the top two administrators.

The administrators and health care providers do, in fact, run institutions that care for the elderly. Seventy percent of hospital administrators say that 50% or more of their patients are age 65 and over; 83% of the home care administrators report that 70% or more of the people they serve are age 65 or over; 89% of the nursing home administrators say that 90% or more of their residents are at least 65 years old. In addition, 70% of doctors report that at least 80% of their patients are age 65 and over; the same is true of two-thirds of the nurses interviewed in this survey.

The three samples of administrators were weighted according to the number of hospitals, nursing homes, and home care agencies in the United States in order to form a representative sample of health care administrators dealing with the nation's elderly population. The samples of nurses and doctors were weighted according to the ratio of registered nurses to licensed physicians.

Estimated Proportion Of Malnourished People Among America's Elderly Population

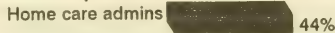
Elderly hospital patients:



Nursing home residents:



Home care recipients:



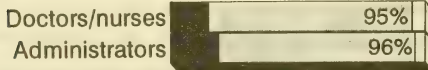
Their own patients:



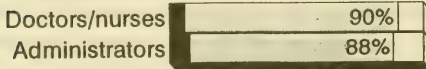
■ Median estimate

The Role Of Nutrition In Health Care

Prevention:



Treatment:



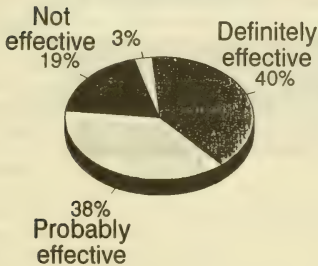
Recovery:



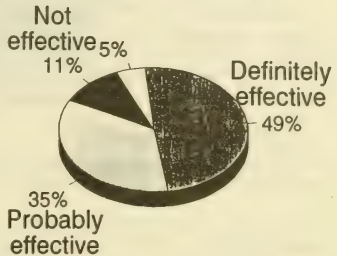
■ Most important role □ Major role □ Minor role/no role

Perceived Cost-effectiveness Of Nutrition Screening And Treatment For Their Own Patients

Administrators

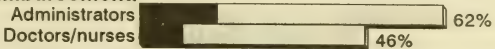


Doctors/Nurses

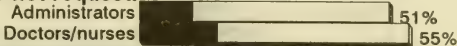


Reasons Nutrition Screening And Intervention Are Not Routine

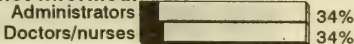
Lack of reimbursement:



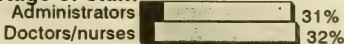
Doctors do not request:



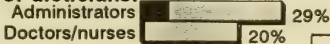
Institutions not informed:



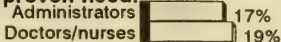
Shortage of staff:



Shortage of dietitians:

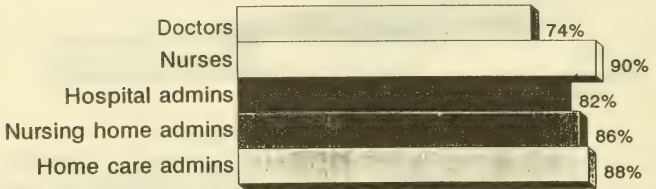


No proven need:

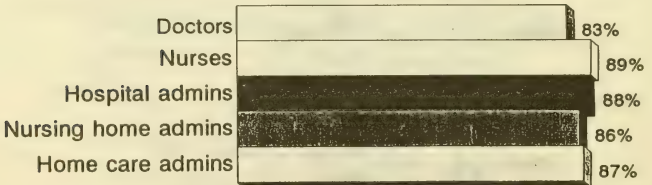


☐ Major factor
☒ Single biggest factor

Nutrition Screening & Treatment Should Be Part Of Basic Benefits Package



Nutrition Screening & Treatment Should Be Reimbursed



Mr. LEWIS. Thank you very much for your testimony.
Ms. Thompson.

STATEMENT OF MARGARET THOMPSON, EXECUTIVE VICE PRESIDENT, THOMPSON WHITE & ASSOCIATES ON BEHALF OF THE AMERICAN SENIORS HOUSING ASSOCIATION, NATIONAL MULTI HOUSING COUNCIL, AND NATIONAL APARTMENT ASSOCIATION

Ms. THOMPSON. Congressman Lewis, I greatly appreciate your invitation to participate in this afternoon's hearing. I will paraphrase my full testimony which has already been submitted.

My name is Peg Thompson. I am executive vice president of Thompson White & Associates, a seniors housing management firm headquartered in Huntsville, Ala. Thompson White & Associates is one of the Nation's largest managers of senior housing with responsibility for seniors housing units and properties located in several States, including large cities and small towns across the United States.

I speak today from 21 years experience with seniors housing and home health services, and a personal deep commitment to assisting older people with their quest to live their lives as proud, contributing citizens of this country.

I am here today on behalf of the American Seniors Housing Association, National Multi Housing Council, and National Apartment Association, three important organizations that support quality, accessible and affordable housing and services for seniors. Members of these three associations own and manage a large portion of the Nation's senior housing stock.

The American Seniors Housing Association represents the country's larger and more respected seniors housing firms. They are sophisticated corporations, many of which own and manage many thousands of seniors housing units in a number of States. Members are engaged in all aspects of senior housing, including ownership, construction, financing, and management of such properties, and therefore are vitally concerned about aspects of a public debate that includes discussion of health care, since concern about health is the highest priority of our residents and their families.

This hearing takes on special importance as Congress and the administration begin to consider the significant challenges of health care reform. Because of its substantial impact on the financial and social health of our system, long-term care is a critical component of the national health care program, and its reform must be included in any legislation that attempts to develop a health care system that seeks to provide all people with access to appropriate services in the most dignified, caring, and cost-effective manner possible.

I strongly believe that the Nation's existing long-term care system needs to be significantly altered to provide frail older people with greater access to affordable supportive care in the most residential setting possible, such as seniors housing.

Since the early 1970s, long-term care in this country has overrelied on institutional and medically modeled settings such as nursing homes, despite the fact that the care needs of frail elderly people are most frequently supportive in nature and not medical.

Although the elderly account for 12 percent of our population, they consume one-third of the Nation's health care budget.

In many respects, the system has failed millions of older people because policymakers have created an industry where competition does not exist. The enormous role that Medicaid plays in paying for nursing home care has stripped older people of any incentive to seek lower cost, long-term care alternatives. The existing long-term care system clearly favors nursing home care, the most expensive option.

The incentive to States is obvious. Provide long-term care services through nursing homes, and have access to an unlimited entitlement.

In recent years, consumers, both older adults and their families, have increasingly sought accessible, cost-effective residential alternatives to nursing homes. Senior housing has emerged as an alternative that has gained widespread acceptance among consumers since the mid-1980s.

A study conducted in September of 1992 by the American Senior Housing Association and Coopers & Lybrand provide clear evidence that senior housing can successfully serve older adults with a variety of supportive care needs.

Surveys of over 70,000 units of seniors housing nationwide found, for example, that the population currently living in seniors housing is on average nearly 82 years old. This surprising statistic demonstrates that our industry is seen as the alternative to the current medical model of long-term care.

The cornerstone of the long-term care component of President Clinton's Health Security Act would provide assessment and care planning benefits to people with three or more activities of daily living needs, and severe cognitive impairments.

Generally speaking, I believe it is a positive development that community-based services are proposed to be eligible for Federal matching funds for assistance with activities of daily living and cognitive impairments. In addition, I applaud the President's desire to give States a great deal of flexibility to determine how funds will be allocated and in what settings they can be used.

On the other hand, because of my background in both home care and in seniors housing, I strongly question the cost effectiveness of providing unlimited home care to people with multiple needs for basic human functions such as bathing, dressing, toileting, meal preparation and financial management.

In these instances, group residential care should be favored over individually catered home care because, one, it provides customer centered facilities and more available staff to address residents' needs. Two, it provides the security and companionship often missing from intermittent health care provision and so vital to preventive health maintenance.

Three, care needs, including emergency needs, can be more easily monitored and therefore more quickly and effectively addressed.

And four, it is much less expensive.

On a more basic level, I am very concerned that the President's plan does not address the critical need to introduce competitiveness into the long-term care delivery system, and would instead leave in

place a long-term care system that has done a disservice to both American's, frail elderly, and the U.S. taxpayer.

In sum, while the Health Security Act could potentially be the impetus for some States to set up an exemplary program such as Oregon's assisted living program, it does not tangibly address the litany of problems that has caused spiraling long-term care costs and unhappy consumers.

Congressman Lewis, I know that working together we can accomplish much for our Nation's older people and their families. And I look forward to working with you and your colleagues in the coming months.

[The prepared statement follows:]

Health Care Reform: Long-Term Care

Testimony of Margaret Thompson
Executive Vice President
Thompson White and Associates, Inc.
Huntsville, Alabama

On behalf of the
American Seniors Housing Association
and
National Multi Housing Council
and
National Apartment Association

Chairman, I greatly appreciate your invitation to participate in this morning's hearing.

This hearing takes on special importance as Congress and the Administration begin to consider the significant challenge of health care reform. Long-term care is a critical component of the reform effort and must be included in any legislation that attempts to develop a health care system that provides frail elderly persons with access to appropriate services in the most dignified, caring, and cost-effective manner possible.

I believe the nation's existing long-term care system needs to be significantly altered to provide frail older persons greater access to affordable supportive care in residential, community-based settings such as seniors housing.

Since the early 1970s, long-term care in this nation has over-relied on institutional medical settings such as nursing homes, despite the fact that the care needs of the frail elderly are most frequently supportive in nature. An efficient and appropriate long-term care system should not over-rely on the expensive services of acute medical care professionals. Gerontologists and other professionals with expertise in the processes of aging have long recognized that the ailments experienced by the frail elderly are chronic in nature, and require non-technical, non-medical supportive services that are most efficiently and inexpensively provided in residential, community-based settings such as seniors housing. This Committee now has an opportunity to redefine our long-term care system to better meet the needs of a burgeoning elderly population with significant savings for the U.S. taxpayer. The seniors housing industry wants to work with you to achieve those objectives.

Introduction

Margaret M. Thompson. Mr. Chairman, I speak today from 15 years experience in the seniors housing industry. I am Executive Vice President of Thompson White & Associates, Inc., a fully integrated seniors housing management firm headquartered in Huntsville, Alabama. Thompson White & Associates is one of the nation's largest managers of seniors housing, with responsibility for seniors housing units in properties located in states.

Organizations Represented. I am here today on behalf of the American Seniors Housing Association, the National Multi Housing Council, and the National Apartment Association, three important organizations that support quality, accessible, and affordable housing and services for seniors. Members of these three associations own and manage a large portion of the nation's seniors housing stock.

The American Seniors Housing Association (ASHA) represent's the country's larger and most respected seniors housing firms. They are sophisticated corporations, many of which own and manage many thousands of seniors housing units in a number of states. Members are engaged in all aspects of seniors housing including the ownership, construction, financing, and management of such properties.

The National Multi Housing Council (NMHC) represents the country's larger and most respected multifamily housing firms. Many members own and manage thousands of rental units in a number of states and provide housing for thousands of older adults. Member firms are engaged in all aspects of rental housing including the ownership, construction, financing, and management of such properties.

The National Apartment Association (NAA) brings together state and local associations of owners, builders, investors, developers and managers of multifamily properties into the nation's largest multifamily housing association. NAA represents more than 200,000 multifamily professionals who own or manage over 3.5 million apartments nationwide.

Commitment to work with the Committee. Mr. Chairman, I know of your lifelong commitment to provide quality, affordable long-term care services for all Americans. I know also that professionals in our industry have devoted their careers to achieving those same goals. My colleagues provide the investment capital and the management expertise that is needed to produce, upgrade and operate seniors housing for hundreds of thousands of Americans.

We share many goals in common. Working together, we can accomplish much for our nation's older adults and their families. I look forward to working with you and your colleagues in the coming months.

Mr. Chairman, your invitation asked the panel to address a number of important questions related to health care reform. My testimony will attempt to address the areas in which my expertise in seniors housing gives me special insights that may be useful to the Committee.

Problems With The Current Long Term Care System

The growth of the elderly population has significant implications for health care reform. According to the U.S. Senate Special Committee on Aging, 7 million older persons needed some long-term care services in 1990 and this number is projected to increase to 12 million persons by 2020¹. The costs associated with providing nursing home care for older persons

¹*Developments in Aging: 1992 Volume I, 1993*

with disabilities is expected to increase much faster, from \$37.6 billion in 1990 to \$112 billion by the year 2020². Medicaid, the federal/state program which provides the 90 percent of public funding for long-term care services has logged three consecutive years of growth in excess of 20 percent, and represents the fastest growing component of state budgets³. Projections indicate, for example, that Medicaid will account for almost one quarter of state budgets by the year 1995⁴.

Since 1970, costs for nursing home care have increased by an annual average of 12.6 percent, increases beyond those experienced by other health care sectors including hospital care, drugs, and physician services⁵. Projections indicate that nursing home expenditures for persons 65 years and older will increase from \$37.6 billion in 1990 to \$64 billion by 2005, and will exceed \$112 billion by 2020⁶. Despite the tremendous resources allocated on nursing home care, however, older consumers consistently report that they would rather die than reside in a nursing home.

Although it is beyond the scope of this hearing to address all of the reasons why the U.S. long-term care system does not work today, I shall address a couple of the more prominent factors. In many respects the system fails millions of older adults (and U.S. taxpayers) because policymakers have created an industry where competition does not exist. The large role that Medicaid plays in paying for nursing home care has stripped the older adult consumer of any incentive to seek lower cost long-term care services. Since most elderly nursing home patients quickly deplete their assets and become dependent on the Medicaid program (63 percent within 13 weeks, and 83 percent within one year of entering a nursing home), seeking lower cost nursing homes will only effect the duration of the Medicaid spend-down period.

While there are a couple of states that have utilized Medicaid-waivers to fund alternatives to nursing homes in residential, community-based seniors housing, the existing long-term care system clearly favors nursing home care, the most expensive care option. The incentive to States is obvious -- provide long-term care services through nursing homes and have access to an unlimited entitlement.

States have controlled long-term care costs by limiting the number of nursing home beds that can be built through moratoria on the issuing of licenses or through certificate of need (CON) restrictions. These practices have created a false scarcity of supply in virtually every state, which has had the effect of ensuring demand for services with little or no regard for quality. For older adults who need assistance with some of the activities of daily living (such as dressing, bathing, and transferring), the practice of artificially controlling the supply of nursing home beds has left many seniors with few choices.

²U.S. Senate Special Committee on Aging, *Aging America: Trends and Projections* 1991

³John O'Connor, "State Medicaid Waivers: Major Increases Ahead?" *Long Term Care News*, August 1993).

⁴Penelope Lemow "The Dilemma of Long-Term Care", *Governing*, June 1992

⁵William J. Scanlon "Possible Reforms for Financing Long-Term Care" *Journal of Economic Perspectives* 1992

⁶Brookings/ICF Long Term Care Financing Model, 1990

The current long-term care system is also fundamentally flawed because it has relied almost exclusively on regulation, rather than competition, to control quality of care in nursing homes. This over-emphasis on regulation has created nursing homes which are institutional in design and operation. The very nature of the nursing home unnecessarily robs the frail elderly of the independence, dignity, and privacy that is available in less-costly residential, community-based seniors housing residences. Although the heavy regulation that afflicts nursing homes has eliminated some of the quality problems that once plagued the industry, it has also had the unintended, but obvious effect of driving up long-term care costs.

The Role of Seniors Housing

In recent years, consumers (including both older adults and their families) have increasingly sought accessible, cost-effective, residential alternatives to nursing homes. Seniors housing, which may encompass a range of products that combine residential shelter, supportive services, and health care, has emerged as one such alternative that has gained widespread acceptance amongst consumers since the mid-1980s. A study conducted in September 1992 by the American Seniors Housing Association and Coopers & Lybrand provided clear evidence that seniors housing can successfully serve older adults with a variety of supportive care needs. The survey of over 70,000 units of seniors housing nationwide found, for example, that the population living in seniors housing is nearly 82 years old.

In addition to providing community-based residential shelter, seniors housing offers residents a wide array of services that enhance independence in a more desirable and less costly setting than a nursing home. In the ASHA/Coopers & Lybrand survey, housekeeping services were available in 86.2 percent of all seniors housing residences; nursing services in 63.1 percent; transportation services in 95 percent; social programs in 81.9 percent; emergency call systems in 96.0 percent; and security systems in 88.9 percent.

Although much of the nation's seniors housing stock is funded entirely by private pay sources, there is strong evidence to suggest that a publicly funded system of seniors housing can also be an effective and desirable alternative to nursing homes. The state of Oregon, for example, has successfully utilized Medicaid waivers to cover assisted living facilities (one type of seniors housing) as an alternative to nursing homes. In this program, Medicaid-waiver client's must be dependent or need assistance with several critical activities of daily living, such as toileting, eating, transferring, bathing, and dressing.

An analysis of the Oregon assisted living program conducted in 1993 for the American Association of Retired Persons (AARP) has demonstrated the potential effectiveness of this approach as an alternative to more costly nursing home care. The program serves a resident population that is, on average age 85, with substantial care needs similar to those of nursing home residents. The AARP analysis of the Oregon assisted living program concluded that:

"Oregon has been able to develop a model of assisted living that is structured to promote independence, privacy, and normal life-style and at the same time has accommodated tenants comparable in disability to

residents in nursing homes."

Importantly, assisted living programs in Oregon averaged about 62.4 percent of nursing home costs for those paying privately and 64 percent of nursing home costs for those receiving Medicaid support⁷.

The Clinton Proposal

The cornerstone of the long-term care component of President Clinton's Health Security Act would provide assessment and care planning benefits to people with three or more activity of daily living needs or severe cognitive impairments. The proposal specifies that the funds can be used in home or community based settings, such as seniors housing, but not in skilled nursing facilities (nursing homes).

Generally speaking, I believe that it is a positive development that community based services are proposed to be eligible for federal matching funds for assistance with activities of daily living and cognitive impairments. In addition, I applaud the President's desire to give states a great deal of flexibility to determine how funds will be allocated and in what settings they can be used. On the otherhand, however, I am concerned that the availability of funding for home care may ultimately act as a deterrent for people to leave their homes and move into a group residential setting, where costs can be more easily controlled and care managed. I personally question the cost-effectiveness of providing home care to severely disabled individuals, who would in many instances, require 24-hour oversight and care.

In addition, the Health Security Act as proposed would leave intact a long-term care delivery system that would remain overly reliant on nursing homes to care for frail elderly persons. This despite an abundance of evidence that nursing homes are universally disliked by consumers, and substantially more costly than seniors housing. Although I believe there is still a significant role for the nursing home in our nation's health care system, nursing homes are most effective providing sub-acute and other rehabilitative services for patients who require short duration care. I also question why the President's plan does not address where to place those existing nursing home residents who do not require the intensity of services provided in this setting. Although estimates vary, it is believed that as many as 30 percent of current nursing home residents do not need the services provided in this setting.(I need some help on this--does anyone have an estimate that we can cite?)

The President's health care reform plan would provide funding for the assessment and development of care plans for the severely disabled. Again, while this would be a positive step, it would leave the actual development and implementation of community-based services to the discretion of the states. Under this scenario, it is difficult to estimate how many states would actually pursue the development of cost-effective alternatives to nursing homes for the severely disabled.

On a more basic level, I am concerned that the President's plan does not address the critical need to introduce competitiveness into the long-term care delivery system and would instead leave in place a long-term care

⁷Assisted Living in the United States, AARP, 1993

system that has miserably failed both America's frail elderly and the U.S. taxpayer. In sum, while the Health Security Act could potentially be the impetus for some states to set up programs such as Oregon's assisted living program, it does not tangibly address the litany of problems that have caused spiraling long-term care costs and unhappy consumers.

Other Options

It is my firm belief that a range of additional alternatives should be explored before the President's or other long-term care reform proposals are accepted by Congress. One of the most disturbing aspects of the Health Security Act is that it does not seek to utilize for long-term care funding one of the largest and most available private resources in the country -- the approximately \$700 billion in home equity owned by Americans over the age of 65. The proposal's increase of payments for home care and services are further disincentives for a person to move out of the home, where needed care and services are expensive to deliver, and into seniors housing, where services, staffing, and appropriate facilities are available on a more cost-effective, managed basis. The following are two specific proposals that offer incentives for older individuals to use private resources to pay for long-term care.

Section 1034 Rollover for Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs), which offer residential living and supportive services, assisted care, and nursing services to elderly persons in return for a lump-sum entrance fee plus regular monthly fees, should be considered as a private alternative to government funding of long-term care costs for the elderly.

A CCRC resident's entrance fee is usually paid from proceeds from the sale of his or her prior principal residence. Entrance fees are used to help defray the cost of lifetime residence and supportive services, assisted living, and skilled nursing care as needed. The advantages of CCRCs include: (1) prepayment or stabilization of some health care costs from the resident's accumulated assets, (2) provision of a continuum of levels of care with an emphasis upon a residential (assisted living), rather than a medical (nursing) model, and (3) furnishing of preventive and managed care, such as a healthful diet, activity programs, routine medical examinations, social support and companionship, etc. The alternative for many elderly persons remaining in their single family homes is to hold out for as long as possible until a catastrophic event results in serious personal injury, hospitalization, and then long-term or perhaps permanent placement in a free-standing nursing facility.

The Brookings Institution study of long-term care concluded that CCRCs are a significant alternative to government-funded long-term care. However, the study noted that a major problem for CCRCs is the reluctance of elderly persons to leave their single family homes.⁸

This reluctance of an elderly person to leave his or her single family home is exacerbated by current tax law. IRS Revenue Ruling 60-135 states that a resident using proceeds from the sale of a prior principal residence to pay

⁸Rivlin and Wiener, *Caring for the Disabled Elderly: Who Will Pay?* The Brookings Institution 1988

an entrance fee to a continuing care type-retirement community where the resident is provided with lifetime services, is not eligible to defer recognition of some or all of the gain under Section 1034 of the Internal Revenue Code. The basis for the Ruling is that the taxpayer does not have an ownership interest in the retirement community, but rather a mere right to occupy a residence.

Historically, CCRCs have been developed by the non-profit sector, using entrance fees, rather than sales of fee simple interests, in order to retain long-term management control over services and to enable the pursuit of the organization's charitable mission. Today the values of prospective resident's homes, as well as the entrance fee requirements for many CCRCs, often exceed the \$125,000 one-time exclusion from income of gain from the sale of a principal residence available to persons over the age of 55. Elderly persons therefore must pay a substantial tax penalty to enter such a community.

As a result, tax policy encourages an elderly person with significant home equity to reinvest in another principal residence with no supportive services, rather than in a CCRC where the assets can be used to help prevent the person from incurring catastrophic health care costs and becoming dependent upon government-funded health care programs. It seems to be in the nation's interest to give elderly persons who use their home equity to provide for their future long-term care needs the same tax benefit available to a person who stays in the same home or sells and reinvests in another residence without health benefits.

The American Seniors Housing Association, National Multi Housing Council, and National Apartment Association would therefore recommend that Section 1034 of the Internal Revenue Code be amended to add Subsection (m) to read as follows:

"Deferral of recognition of gain from the prior sale of a principal residence shall be permitted under this Section to the extent such proceeds are used as an entrance fee to gain admission to a "qualified continuing care retirement community" as defined in Section 7872(g) by an individual who has attained age 55, and who resides in the qualified continuing care retirement community as the taxpayer's principal residence. Any gain deferred pursuant to this Subsection (m) shall be recognized whenever the taxpayer and his spouse, if any, cease to use the community as their principal residence."

This proposal would encourage elderly people with sufficient financial means to convert their home equity to provide for their long-term care needs, rather than spend down their assets to become eligible for Medicaid. Moreover, the preventative, managed-care, residential orientation of the CCRC environment likely would result in better overall health and social welfare for the older person, resulting in an overall lessening of the burdens of government.

Exclusion of Gain From Sale of a Principal Residence by Persons age 55 and Over

Internal Revenue Code Section 121 permits a taxpayer who has attained the age of 55 before the date of the sale or exchange of his or her principal residence to exclude from gross income up to \$125,000 of gain from the

transaction. The property must have been owned and used by the taxpayer as a principal residence for at least three of the previous five years. The election is a once-in-a-lifetime opportunity.

The exclusion from income of a portion of the gain from the sale of an older person's principal residence was enacted in 1964 and excluded all gain from the sale of residences valued at \$20,000 or less, with modest exclusions for homes valued in excess of \$20,000 determined according to a formula. In 1976, the exclusion amount was raised from \$20,000 to \$35,000. In 1978, Congress determined that the formula was "unrealistic in view of increased housing costs and lowered retirement ages." (House Report to P.L. 95-600). Congress raised the exclusion amount to a flat \$100,000 and lowered the eligibility age from 65 to 55.

In 1981, the \$100,000 exclusion amount was raised to \$125,000 and has not been raised since. If the \$125,000 exclusion amount had been increased in accordance with the United States Department of Labor Consumer Price Index for Urban Consumers, it would now exceed \$212,000.

Section 121 of the Internal Revenue Code should be amended to provide for an increase in the exclusion of gain from the sale of a principal residence for a person 55 years of age or older from \$125,000 to \$200,000 provided that the gain in excess of \$125,000, up to a total of an additional \$75,000, is (1) placed in trust for the sole purpose of providing long-term care, (2) used to gain entrance to, or on-going residence in, a qualified Continuing Care retirement Community as defined in Section 7872 of the Internal Revenue Code, or (3) used to purchase long-term care insurance that conforms to the National Association of Insurance Commissioners Model Long-Term Care Insurance Act, and to additional standards to be adopted by the Department of Health and Human Services.

Long-term care should be defined to include assisted living or residential care services, home health care, and nursing services. Taxpayers would be required to exercise their option of dedicating the capital gain to long-term care needs (by placing it in a trust, purchasing prepaid insurance, or purchasing a continuing care contract) within two years after the sale of the prior principal residence. This would coincide with the two-year reinvestment period for rollover of capital gain described in Section 1034 of the Internal Revenue Code.

Conclusion

Mr. Chairman, because of the rapid aging of the U.S. population, it is in the public interest that this Committee include significant long-term care reform in any overhaul of the U.S. health care system.

I believe that there are many ways to reform long-term care so that frail elderly persons and others who are severely disabled can receive necessary services in more desirable residential, community-based seniors housing for significantly less than it is currently costing the U.S. taxpayer.

I deeply appreciate your invitation to be here this morning, and I hope you can accept my sincere invitation to work with me and my colleagues in the seniors housing industry to provide better long-term care for all Americans.

Mr. LEWIS. Thank you very much for your testimony.

I thank each member of the panel for being here. Thank you very much.

The members of the next panel may come forth. Thank you very much for being here.

Let's start with Dr. Hill.

Dr. HILL. Thank you.

Mr. LEWIS. Dr. Hill, and each member of the panel, you may state your name and the organization or the agency you may be representing. I will do very little talking.

Dr. HILL. OK, thank you.

STATEMENT OF LAWRENCE HILL, D.D.S., PRESIDENT, ASSOCIATION OF COMMUNITY DENTAL PROGRAMS, COALITION FOR ORAL HEALTH

Mr. Chairman, I am Dr. Larry Hill. I am the dental director of the Cincinnati, Ohio Department of Health, and I am president of the Association of Community Dental Programs. I have been personally involved in dental public health programs for the past 19 years. I am here today on behalf of the Coalition for Oral Health.

While the coalition is pleased that the administration's plan would provide dental care for children from the outset, we are very concerned that most adult care would not be mandated until the year 2001. I am here today to urge you to include dental care for both children and adults from the outset in a modest, cost-effective health benefits package.

Dental diseases are not just cosmetic problems. They are potentially very serious infections that occur only inches from the brain. For example, oral cancer is more common than cancers of the brain, liver, bone, stomach, cervix, ovaries; and leukemia. If detected early, it is over 90 percent curable. But since so many people fail to get these routine oral examinations, most oral cancer is already advanced when diagnosed and kills more people each year than cervical cancer.

Dental care, just like the treatment of infections anywhere else in the body, affects overall health and is critical for diabetics, persons with blood disorders, renal transplant patients, and patients on chemotherapy or radiation therapy. Thirty percent of the initial signs of HIV infection are found in the mouth, so the dentist is often the first person to diagnose the disease. Yet over 150 million Americans have no dental insurance.

Low-income adults who have no access to oral care often have to use hospital emergency rooms for dental problems. One such teaching hospital in Texas has over 550 emergency room visits per month for dental infections, at a cost of at least a half a million dollars per year. It is not unusual for a single untreated infection to necessitate an 8-day hospital stay, and cost \$7,000. Delayed treatment can become life-threatening.

Parents must be eligible for dental care if their children are to be assured access. Adults who do not get dental care too often don't take their children to the dentist.

In Cincinnati when our local health department had a dental program in a neighborhood health center that was for children only, the program was underutilized. When we expanded it to in-

clude adults, we became inundated with both children and adults. Soon after, there was a waiting list of over 1,000 people, and that waiting list continues to grow today by more than 30 people a month.

Dentistry is the classic public health success story, having led all the health professions in the development of preventive procedures. The increasing number of people receiving dental insurance since 1970 shows that those who have insurance are twice as likely to visit the dentist, and the need for more costly dental treatment diminishes greatly for people who receive preventive dental services.

On behalf of the 150 million people without dental coverage, we urge you to recognize the inherent problems with placing secondary importance on oral diseases. To encourage prevention and reduce costly treatment, we ask that health care reform include a minimum dentistry package of oral health benefits for adults and children at its inception.

Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF LAWRENCE HILL, D.D.S.
PRESIDENT
ASSOCIATION OF COMMUNITY DENTAL PROGRAMS
THE COALITION FOR ORAL HEALTH**

INTRODUCTION

The Coalition for Oral Health is a growing organization that recognizes the importance of oral health as an integral component of overall health and is committed to obtaining access to oral health for all. Members of the Coalition, representing over 150,000 people nationwide, include a consumer's alliance, public health professionals, dental educators and researchers, African-American, Hispanic, and other dental providers, representatives of community and migrant health centers, and the dental industry. We are not aware that such a diverse alliance has ever come before Congress in support of the oral health of the public. A description of the organizations supporting this statement is attached.

The Coalition supports the universal availability of health services for all U.S. residents and is grateful that the Clinton Administration has recognized the importance of oral health by including a basic package of dental benefits for children and emergency care for adults from the outset of its proposed Health Security Act. Inherent in the President's plan is the fact that the mouth is part of the body and that oral health is integral to general health. As stated by former U.S. Surgeon General Dr. C. Everett Koop: "You're not healthy without good oral health."

The Coalition believes that everyone should be entitled to at least the modest package of dental benefits essential to diagnose disease, relieve pain, treat infection, and provide proven preventive services. Most people are unaware of the prevalence of oral cancer or that dental decay and periodontal diseases are bacterial infections which, like pneumonia and other bacterial infections require treatment. We urge the Subcommittee to create a benefits package that covers treatment of infections -- whether in the foot, the stomach, the arm, or the mouth -- for both children and adults.

Health care reform has been driven by a number of factors, including the lack of access for the 37 million individuals without medical insurance. Our focus is the 150 million people without dental insurance, who are left vulnerable to the hidden epidemic of oral diseases and their adverse impact on overall health.

The Coalition recommends a basic benefit package that includes diagnosis, emergency care, prevention, and primary care -- a benefit package both humane and cost-effective. We want to assure that people with special needs are provided the services they need to be able to function. The basic but essential oral health services we advocate have been described as a "minimum decency package".

**THE CASE FOR IMMEDIATE INCLUSION OF A MODEST ADULT
DENTAL BENEFIT PACKAGE**

While the Coalition is pleased that the Administration's plan includes emergency oral health care for adults immediately and phases in preventive and basic restorative services by the year 2001, we believe that the benefit package must be broadened to include preventive and primary care for adults from the plan's initiation.

Dental diseases are not just cosmetic problems. We urge the Subcommittee to assure coverage of all medically necessary oral health care. Medically necessary oral health care is a direct result of, or has direct impact on, an underlying medical condition. It includes care directed toward control and/or elimination of pain, infection, and reestablishment of function. There are a variety of serious diseases and conditions that can be complicated where oral health is not properly attended to.

For diabetics, any infection can be life threatening, because the infection exacerbates the diabetes and precludes control of elevated blood sugar levels. In this context, it is important to remember that periodontal diseases and dental caries are the most common infections in adults.

For those with a blood disorder, gingival (gum) bleeding can be life threatening. Those at risk include hemophiliacs and those with HIV disease.

Renal transplant patients, those on chemotherapy, and anyone with an immune deficiency are vulnerable to the uncontrolled progression of the herpes simplex virus (fever blisters). The virus can spread to the brain and spinal cord in those who are immunosuppressed. When uncontrolled, this often results in death.

For those receiving radiation therapy, a dental abscess or infection frequently becomes uncontrolled and destroys the surrounding bone or even the jaw itself, leading to mutilation and sometimes death. Rampant decay is a common complication due to the destruction of the salivary glands.

Bacteria from oral infections can similarly spread through the blood stream and attach to heart valves and other prosthetic replacements in patients who have heart murmurs from congenital or acquired heart defects. This results in death 50% of the time.

For patients on chemotherapy, oral infections can spread unchecked through the blood stream because of the absence of natural defenses. Mouth infections are the most common infections in chemotherapy patients and therefore are a major cause of life threatening disease in these patients.

Most people are surprised to learn that oral cancer kills more people in the United States every year than cervical cancer. Oral cancer is more common than cancer of the cervix and ovaries as well as leukemia, melanoma of the skin, Hodgkin's disease, and cancers of the brain, liver, bone, thyroid gland, and stomach. While over 90% of oral cancers can be cured if detected early, most oral cancer is "late stage" before it is detected. Each year approximately 30,000 people are diagnosed with oral cancer, and 8,000 people die from it. Many of those who survive require extensive and costly treatment including surgery, chemotherapy and/or radiation therapy. Treatment costs generally range from \$40,000 to \$100,000 per case and even those who survive have significant disability and lost productivity.

Treatment of oral cancers accounts for costs of \$1.0 to \$2.3 billion annually. It is estimated that lost wages add an additional \$1 billion or more to the annual cost of oral cancer. Providing oral examinations to prevent oral cancer offers an opportunity to shift costs from those required for treatment to disease prevention. In doing so, it is estimated that 94-98% of oral cancers can be intercepted in the precancerous stage and prevented.

While one wouldn't think of designing a benefit package that didn't include pap smears as a measure to detect and prevent cervical cancer, oral examinations to detect oral cancer are not included in the President's plan until 2001. If regular oral examinations of adults are not covered in the national health care benefit package, many persons would be denied the opportunity to have this life-threatening disease detected early, thus contributing to needless deaths, and increasing the chances of disfigurement as the result of extensive surgery that could have been prevented. Dental professionals are trained to detect and diagnose oral cancer. They are far more likely to carefully examine patients' mouths than are other health care providers. Further, these same examinations that are critical for detecting oral cancers can provide early diagnosis of other serious health conditions. Examples include: HIV disease, nutritional disorders, leukemia, diabetes, lymphomas, bulimia, and anorexia.

Because the earliest manifestations of HIV disease often occur in the mouth, dental professionals play a critically important role in the early detection of this disease. Such early detection means earlier therapeutic intervention is possible, thus extending the productive life spans of affected individuals and improving their quality of life.

Other preventive services for adults have also proven their cost-effectiveness. Topical fluorides can prevent root caries (decay) in adults. Periodontal (gum) services can prevent the complications of diabetes, and, in general, foster the establishment of a functional, pain-free dentition which is essential to overall health, proper nutrition, and the prevention of disease. The provision of simple restorations brings significant out-year cost savings for adults by reducing the need for more complicated treatment. According to the National Institute of Dental Research, nearly \$40 billion was saved on dental treatment costs in the 1980s because of improvements in

oral health attributable to the widespread use of fluorides, increased use of preventive services by practitioners and fewer patients needing dentures. The Coalition recommends including in the basic benefit package preventive and primary services for adults as well as children from the outset.

Poor and low income adults with limited or no oral health care coverage do not have access to routine preventive and oral care through the existing dental care delivery system. Because Medicaid dental services for adults are considered optional, some states provide no dental coverage for adults, most of the remainder provide only emergency treatment or very limited restorative services. More states are considering eliminating adult dental services as the country's economic situation continues to strain state budgets.

The Coalition is encouraged by the growing recognition by Congress and the Administration that Medicaid needs reform. Dental Medicaid is especially problematic as it has been chronically underfunded, suffering from designation as a discretionary service. There is no dental "safety net". As in medicine, the hospital emergency room is often the primary source of oral health care for the poor. Not only is this the most expensive way to provide care, but too often the care required would not have been necessary if the patient could have had access to preventive and early interventive oral health care. Moreover, unless there is a dentist available, patients with dental problems will be given only temporary relief — the underlying problem, still untreated, will resurface at a later time. In reviewing hospital admission rates for groups of dental procedures, we see the even more costly results of lack of access and coverage among low income patients. When admission rates were reviewed for dental conditions, major differences were found in hospital admission rates for dental conditions between low and high income areas. In New York City, for example, low income areas have admission rates 2.7 times higher than high income areas for this dental grouping. In their study of ten states (California, Florida, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Oregon, Washington, and Vermont), low income areas had admission rates that were about 2.4 times higher.

A teaching hospital in Texas has over 550 emergency room visits per month for dental pain and infection. University officials estimate a cost of at least \$100 per visit for these patients — or one half million dollars annually in emergency room costs. A hospital in North Carolina indicates that between five and eight percent of its emergency room visits are for dental care, which, combined with emergency patients seen at the hospital dental program, totals over 625 emergency dental visits per month. Similarly, a New York City hospital dental program reports 860 emergency room dental visits per month. An example of the costs associated with pattern of care is the patient with an untreated dental abscess who required hospitalization for 8 days in New York City at a cost of \$7,000.

The access problems that lead patients to turn to emergency rooms for their care occur throughout the U.S. In Rhode Island, the state health department receives approximately 10 calls each day from residents in desperate need of emergency dental care. After having exhausted the phone book listings of dentists, these people are referred to one of 3 community health center programs, where they are placed on a waiting list of from 3 to 18 months.

Adult oral health also affects employability and self-esteem, as highlighted in the state of Maryland's "Project Independence" program. This is a job training program for welfare recipients, and is mandatory for those with children over age 3. The state's Secretary of Economic and Employment Development noticed that program participants he met held their hands to their mouths and seldom smiled; they were embarrassed by their decayed teeth. A typical client had many lost and broken teeth and teeth riddled with cavities; treatment of the dental disease helped her to get a job. A state partnership with the University of Maryland at Baltimore Dental School allows participants to receive dental treatment at \$10 a visit. The program has demonstrated the connection between oral health, self-esteem, and employability.

Dental care is critical to maintaining the general health of special patient groups, including those with developmental disabilities, birth defects, genetic disorders and acquired medical disabilities. These people often face catastrophic costs because they require special care just to be able to function. Hospitalization and general anesthesia may be needed to treat children with "nursing

bottle caries" cases costing several thousand dollars. Children with facial deformities so severe that they cannot eat, chew or talk properly need orthodontic care to correct their handicapping malocclusions (bites). Those born with genetic conditions such as ectodermal dysplasias need dentures because they have few or no teeth. And cleft lip/palate patients require surgical intervention and dental appliances to gain function. While we are pleased that the Administration's plan recognizes the need for care for those with genetic disorders, we want to assure all special patients that they not have to worry that they will "fall through the cracks" — that payment for their oral health care may be denied because it is classified as "dental" by their medical insurance plan and as "medical" by their dental insurance plan, if any.

CHILDREN'S PRIMARY ORAL HEALTH CARE

The Administration's plan to require the provision of preventive and primary care dental services for children is both scientifically sound and just. This will give all children the opportunity to experience the dramatic improvements in oral health possible with today's proven preventive and restorative techniques. Inclusion of all children is important because dental caries (tooth decay) — the most prevalent of all chronic diseases — eventually afflicts almost the entire population. Eligibility tiers based on income inevitably leave many vulnerable children just beyond the cut off and subject to unnecessary disease, pain and dysfunction.

An example from the Head Start program illustrates the importance of children's oral health care. A Head Start program health coordinator noted a child in the program who was not socializing with other children, did not seem to comprehend the teacher's lessons, didn't respond to questions and didn't participate in group activities. In essence, the child was exhibiting asocial behavior. Coincidentally, this child eventually remained the only child in the program whose parent had not arranged for the required dental exam and follow up care. When program staff got the child to a pediatric dentist, she discovered advanced decay, multiple abscesses, and broken off teeth with sharp edges. The problems were so severe that the child had to be treated under general anesthesia in a local hospital outpatient surgery department. Within one week after treatment, this little boy began to play with the other children. We must consider the potential for diminished capacity to learn at best and aberrant social behavior at worst had this child not been able to get necessary dental care.

Requiring that all children have access to primary and preventive oral health services is especially important for disadvantaged children. Among school aged children, poor, minority, handicapped, and other underserved children experience most of the decay—the very children whose access to oral health services is most restricted because of their families' income, ethnicity, or disabling conditions. Unfortunately, the Medicaid program has been an empty promise for these children. Despite the fact that dental benefits are federally mandated for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, fully 80 percent of Medicaid children fail to receive any dental services in a given year.

There is some early evidence that when adults receive dental care, their children are many times more likely to receive care than are children whose parents do not receive care. This is born out in the experience of Coalition members and is yet another reason why the Coalition believes that the best public policy is to assure universal access to basic benefits for children and adults, stressing prevention and primary care.

THE IMPORTANCE OF PREVENTION AND DENTAL INSURANCE

We are pleased that Congress and the Administration are committed to designing a plan that moves us toward prevention and away from costly treatments. Dentistry is the classic public health success story, having led the health professions by developing a formidable, extensive, well-researched, and cost-effective set of preventive procedures. Unlike many medical conditions that are self-limiting (colds, flu, etc. which run their course without the necessity of a medical intervention), untreated oral diseases typically become more serious, more difficult, and more expensive to treat. The consequences of not treating oral disease extend well beyond the more

obvious health consequences such as the severe pain of toothache (which has been characterized as one of the most excruciating types of pain), and inability to chew food, to the more serious general health consequences of severe systemic infections, psychosocial problems, impaired nutrition and weight loss, severe disfigurement, and death. In nearly every case of oral disease, early detection and treatment saves emotional, physical, and financial costs. Every dollar invested in a simple filling saves at least \$8 in the more expensive restorative care that would be required if the problem were left untreated.

In fact, dental care is one of the success stories in the health industry in the past 20 years. In 1970, when only 6 million Americans had dental benefit coverage, most visited the dentist only when they needed major treatment — a root canal, crown, tooth extraction or gum surgery. Today, many of those with dental coverage seldom need treatment more complicated than a simple cleaning or filling because they visit dental professionals regularly for routine care. Even those who require more complicated treatments need require them far less often than in the past.

So effective is preventive dentistry that dental insurance plans often include incentives to encourage beneficiaries to receive examinations, cleanings, and fluoride treatments. Dental insurance usually provides 100% reimbursement for preventive services, while requiring copayments for restorative services.

Despite the fact that people better understand the importance of prevention, having dental coverage is still the single highest predictor of whether a person obtains oral health care. People with dental benefits are almost twice as likely to visit a dental office in any given year. Almost 50% of those without coverage failed to visit a dental office last year, many delaying treatment until a condition had progressed to an acute or irreversible stage. That is why the Coalition also supports the continuation of the favorable tax treatment for dental insurance plans. We fear that the current dental access problem would be greatly exacerbated if dental coverage was taxable to employees or not fully deductible to employers.

CONCLUSION

The public recognizes the importance of dental care. In Oregon, where inclusion of services under their Medicaid waiver was based on cost effectiveness and consumer input, all dental services except for implants and treatment of temporomandibular joint disorders will be funded for all age groups. A recent study of 857 AIDS patients who were clients of the Robert Wood Johnson Foundation's AIDS Health Services program in 9 U.S. cities found that more respondents reported a need for dental care than for any other service need. And this Subcommittee has heard from Hewitt Associates that "most employees with major employers now get dental benefits as part of their health plans and that the employees highly value such plans. If a uniform plan design were to cause them to lose access to those benefits, negative employee reaction would be considerable." According to the Hewitt Associates testimony, dental plans rank second only to medical plans in employee attitude surveys concerning preferred benefits; dental plans rank ahead of paid time off, ahead of pension benefits, and ahead of life insurance.

We believe strongly that a basic package of preventive and primary health care benefits, including comparable oral health benefits, should be required to be available in both private and community-based settings to all persons.

Our recommended oral health benefit package is detailed below. In general, the benefit package the Coalition recommends is intended to incorporate basic diagnostic, preventive, and treatment services that have been proven effective in preventing and controlling dental and oral diseases and defects. We are recommending some of the least costly and most cost-effective health services available.

**COALITION-ENDORSED ORAL HEALTH CARE
"BASIC" COVERED BENEFITS**

The Coalition for Oral Health proposes that the following basic benefit package be mandated as part of the required health care benefit package for children and adults:

1. Preventive Services
 - A. Professional Oral Health Assessment. A thorough annual examination of hard and soft tissues of the oral cavity and related structures, including necessary radiographs and counseling.
 - B. Dental Sealants. The chewing surfaces of permanent molar teeth are those that are most susceptible to tooth decay. Dental sealants, plastic coatings applied on these surfaces, offer the greatest protection against this decay.
 - C. Professionally-Applied Topical Fluoride. Topical fluoride application for children and adults who are assessed to be at high risk for dental caries.
 - D. Oral Prophylaxis. An annual dental cleaning.
 - E. Fluoride Supplements. This preventive prescription would be available for children up to age 13 in areas where the fluoride level of the community's water supply is less than optimum.
 - F. Space maintenance for children 3-12 years of age. This procedure prevents orthodontic complications for permanent molar teeth that would be prevented from normal eruption if the space were not maintained.
2. Acute, Emergency Dental Services. Coverage includes services which eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial region.
3. Early Intervention Services (to maintain and restore function)
 - A. Restorative Services. Dental fillings with FDA-approved materials, excluding metal castings and cosmetic services.
 - B. Endodontic Services (root canals) for those up to age 18.
 - C. Periodontal Maintenance Services. Basic, non-surgical periodontal (gum) therapy, beyond tooth cleaning and polishing, for those 15 years and older.
4. Special Needs Patients. Special needs patients include, but are not limited to, those with developmental disabilities, regardless of age (e.g. birth defects such as cleft lip/palate and genetic disorders such as ectodermal dysplasia and Sjögren's Syndrome), and acquired medical disabilities from either traumatic, neoplastic, or infectious disease (e.g., tuberculosis, HIV, oral cancer). The benefit package includes those services required to assure special needs patients the above package of basic oral care and additional services they require to have a functional dentition, including, when necessary, hospitalization and general anesthesia, orthodontic care for handicapping malocclusions, and appropriate prosthodontic care for those with ectodermal dysplasia and other genetic disorders.
5. Dentures. Removable prosthodontics to restore function are included, using a phased-in approach. Initially, full dentures are covered, limited to no more than one set every 8 years, except for special needs patients. Partial dentures would be phased in as rapidly as the system would allow.

Fundamental to our proposal is that any medically adjunctive oral health care is covered. Also inherent in the proposal is recognition that, if a dentist is licensed to provide a covered service in the health plan, then the dentist should be allowed to provide those services and be reimbursed in the same manner as any other provider in the plan. In addition, health plans should not discriminate in participation or reimbursement against providers who are licensed to perform services and are practicing within the scope of their license.

While the oral health of many thousands of citizens would benefit from the provision of other dental procedures (e.g., crowns, bridges, and removable partial dentures), this benefit package, in the interest of containing cost, allows for only the most basic of dental services. The premium (which has been adjusted to reflect 1994 fee schedules) for this preventive and primary oral health package for children and adults would cost less than \$10 per month.

COALITION FOR ORAL HEALTH MEMBERS SUPPORTING THIS STATEMENT

AMERICAN ACADEMY OF ORAL MEDICINE was established to combine the knowledge and skills of dentistry and medicine to promote total health care. Members' practices are involved with the diagnosis and treatment of diseases which primarily and secondarily affect the oral cavity and its adjacent structures and care of the medically compromised.

AMERICAN ACADEMY OF ORAL PATHOLOGY represents the specialty of dentistry that provides clinical and laboratory services to private practitioners, institutional and hospital dentists, physicians, and pathologists. Their services are critical for development of a primary health care program that emphasizes early detection and prevention of cancer, the oral management of AIDS patients, and the early detection and management of transmissible infectious diseases.

AMERICAN ASSOCIATION FOR DENTAL RESEARCH represents over 4,500 professionals involved in oral health research throughout the United States. The Association promotes research to improve oral health worldwide and fosters dissemination of scientific advances relevant to oral health. The association facilitates communication, collaboration, and research training and education within the scientific community. The AADR is a Division of the International Association for Dental Research.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted.

AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS represents the 6,000 oral and maxillofacial surgeons in private and academic practice and whose members provide to patients extensive office and hospital based oral and maxillofacial surgical care.

AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY represents the specialty of dental public health. It has a diverse membership of oral health professionals. AAPHD's primary focus is to improve the oral health of the public, using principles and methods of public health practice.

AMERICAN DENTAL HYGIENISTS' ASSOCIATION is the largest national organization representing the professional interests of approximately 100,000 licensed dental hygienists across the country. To improve the public's total health, the mission of the ADHA is to advance the art and science of dental hygiene by increasing the awareness to and ensuring access to quality oral health care, promoting the highest standards of dental hygiene education, licensure and practice, and representing and promoting the interests of dental hygienists.

AMERICAN DENTAL TRADE ASSOCIATION founded in 1882, represents Dental Distributors; the Dental Laboratory Conference (leading Dental Laboratories) and dental manufacturers. The objectives of ADTA are to promote and encourage the development, production, and distribution of equipment and materials for the dental profession, dental schools, and dental laboratories so as to enable its members to perform the highest degree of useful service for the public.

AMERICAN PUBLIC HEALTH ASSOCIATION represents 32,000 formal and 20,000 affiliate members in all disciplines of public health. The Association promotes and protects personal and environmental health.

AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN is the oldest advocacy group within dentistry for promotion of oral health for the children in the United States. Its distinguished history goes back to the middle 1920s and it remains today a coalition of specialists of pediatric dentistry who deeply believe that the dental professions must always focus on preventive dentistry for the child patient population and for the reclamation of dental health for dentally diseased children.

ASSOCIATION OF COMMUNITY DENTAL PROGRAMS is an organization comprised of dental directors and dental program personnel of local and county health departments and staff of any other community based dental public health programs. The mission is to assure access to dental prevention and treatment services to all constituents in a cost effective manner by minimizing duplication and sharing information and methods.

ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS is an organization which represents eleven Historically Black Health Professions Schools in the country. The primary focus of the association is to seek the improvement of the health status of minority communities.

ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS is a voluntary professional organization whose members are the directors of public oral health programs in the states and U.S. territories. ASTDD is an affiliate of the Association of State and Territorial Health Officials.

CLINICAL DIRECTORS NETWORK, REGION II, INC. is a peer organization providing collegial support, networking, education, and research opportunities for primary care clinicians practicing in Community Health Centers.

FEDERATION OF SPECIAL CARE ORGANIZATIONS IN DENTISTRY is an umbrella organization for the American Association of Hospital Dentists, Academy of Dentistry for the Handicapped, and the American Society for Geriatric Dentistry. The federation joins together organizations of like missions to stimulate teaching, education, research, and patient care for special populations including the mentally and physically challenged, medically compromised, and the elderly and frail.

HISPANIC DENTAL ASSOCIATION was founded in January 1990 and currently represents 642 members. The mission of HDA is to provide leadership and represent professionals who share a common commitment to improve the oral health of the Hispanic community.

KENTUCKY ORAL HEALTH CONSORTIUM, INC. is an organization promoting awareness of the effects of dental disease on the health of all Kentuckians, stimulating oral health program development, and fostering pilot projects that support or promote the prevention of dental disease and improved access to oral health services.

NATIONAL ALLIANCE FOR ORAL HEALTH is a coalition addressing the oral health needs of special patient populations. NAOH is a non-profit coalition of voluntary health groups, professional health-related organizations, and individuals who are united by their common concerns for the needs of special patient populations.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS represents 560 organizational members. NACHC has aided and overseen the growth and development of community and migrant health centers and worked to bring health center administrators and clinicians together with consumers on the state level to aid them in development of their own advocacy network.

NATIONAL DENTAL ASSOCIATION represents ethnic minority dentists and allied dental professionals in the United States and the communities they serve. Their mission is to improve the oral health status of the medically underserved and disenfranchised by increasing the number of minority providers, researchers, and educators.

NATIONAL NETWORK FOR ORAL HEALTH ACCESS is an organization of dental providers practicing in community, migrant, and homeless health centers with the goal of improving the health status of the unserved and underserved through improved and increased access to oral health care.

Mr. LEWIS. Thank you very much, Dr. Hill.
Dr. Osborn.

**STATEMENT OF THOMAS OSBORN, D.D.S., PRESIDENT-ELECT,
AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL
SURGEONS**

Dr. OSBORN. Thank you.

Good afternoon. My name is Dr. Thomas Osborn, and I am the President-elect of the American Association of Oral and Maxillofacial Surgeons. I am here to share the views of more than 6,000 oral and maxillofacial surgeons on how the Health Security Act may be improved to provide the highest quality of oral health care for services covered under this plan.

Oral and maxillofacial surgery is a specialty within the profession of dentistry. Following graduation from dental school, oral surgeons complete a dental, medical, and surgical postdoctoral program spanning a minimum of 4 years. Because of this specialized education, oral surgeons are licensed by States to perform procedures that are also performed by medical doctors.

What we are most concerned about in health care reform is that discrimination based on the academic degree of the provider not be a part of any new health care delivery system. If two health care professionals surgically repair a jaw shattered in an automobile accident, and one has an M.D. and the other a D.D.S. degree, their eligibility to participate in a plan or to receive reimbursement should not be dictated by their academic degree.

Degree of provider discrimination ignores the skills and training of the provider and looks only at the type of degree a health care professional received. It harms the patient in that it sharply limits patient freedom of choice.

Where such discrimination now occurs, patients are told that an otherwise covered procedure will not be reimbursed if performed by a D.D.S., but will be covered if performed by an M.D. What this means to patients is a choice between paying out of the pocket for a covered service to receive care from the provider of their choice, or going to an unknown provider who may not be as qualified or experienced.

No health care reform legislation should permit such degree of provider discrimination. As proposed, the Health Security Act partially addresses this issue. The act's definition of health professional and health professional services encompasses all individuals legally authorized by States to deliver health care services. By not distinguishing between M.D.s and other health care providers, the act eliminates some opportunities for discrimination. This offers only a partial solution.

It is important that the act expressly prohibit any health plan from discriminating in participation and reimbursement against an oral surgeon licensed under applicable State law based solely on the academic degree of the provider.

This approach, which is consistent with Medicaid and Medicare law, and laws in 48 States, would not increase the cost of health care plans, and would not require that any additional or related services be covered. Rather, it merely prohibits a plan that already provides coverage for certain services from discriminating against

an oral surgeon solely because he or she is a dentist and not a medical doctor.

Our approach would maintain the bargaining authority of plans to develop the best combination of services and providers, while protecting the rights of the oral surgeon against unfair discriminatory practices that have no fiscal or qualitative benefit to patients and the plan subscribers.

Thank you for this opportunity to testify. We have provided additional background material in our written statement, which we would ask that you include in the record.

Thank you.

Mr. LEWIS. Without objection, it will be included.

[The prepared statement and attachments follow. Some of the background material is being retained in the committee files:]

TESTIMONY OF THOMAS OSBORN, D.D.S. AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

I. INTRODUCTION

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to present this statement and convey our views on the Health Security Act of 1993.

The AAOMS, founded in 1918, represents more than 6,000 oral and maxillofacial surgeons, and is one of the oldest surgical specialty organizations in the United States. Oral and maxillofacial surgery (OMS) is the surgical specialty of dentistry that deals with the diagnosis, and surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

An oral and maxillofacial surgeon is a dental school graduate who has completed a postgraduate hospital residency in an accredited oral and maxillofacial surgery training program, including a core surgical year. This year of comprised of rotations in internal medicine, general surgery and anesthesia services. In addition, she or he completes a minimum of 30 months of surgical training focused in the maxillofacial region. Oral and Maxillofacial surgeons treat a significant number of patients in an outpatient setting. Their expertise in this area includes in-depth knowledge of ambulatory general anesthesia and sedation, gained through residency training and an in-office evaluation program required by the specialty. The AAOMS is dedicated to continuing education, clinical research, and quality of patient care in the field of oral and maxillofacial surgery.

The AAOMS has been progressive in its endeavors to advance the specialty of oral and maxillofacial surgery. Through the establishment of the Oral and Maxillofacial Surgery Foundation, the specialty has committed itself to continuing improvement of patient care through support of education and research. The OMS has raised more than \$5.1 million for the Foundation's Endowed Research Fund to ensure the long-term availability of funding for research in oral and maxillofacial surgery. In the past two years alone, the OMS has awarded \$380,000 to research applicants.

Furthermore, the AAOMS has been in the forefront of the health care field as one of the first specialties to develop parameters of care. The establishment of these parameters provides a means to assess the appropriateness and quality of treatment to patients treated by oral and maxillofacial surgeons. This represents the strong commitment to patient care and accountability of the specialty of oral and maxillofacial surgery.

The AAOMS was one of the eighteen specialties examined in Phase I of the Harvard Resource-Based Relative Value Study. Since then the AAOMS has worked closely with Harvard, the Physician Payment Review Commission and the Health Care Financing Administration to refine the Medicare payment system.

II. AAOMS POSITION AND VIEWS ON HEALTH CARE REFORM

In viewing the development of health care policy, the AAOMS has identified some issues with respect to health care reform legislation of critical concern to oral and maxillofacial surgeons.

The most important issue for any health care provider is to assure that patients have access to care, and that providers have the ability to provide it as well and as efficiently as possible. With that in mind, our central concern is that any health care reform plan not permit discrimination against oral and maxillofacial surgeons because of their academic degrees in dentistry.

Degree of provider discrimination occurs when a licensed and highly trained oral surgeon is subjected to diminution of authority, refusal of reimbursement, or restriction in providing services solely on the basis on his or her academic degree. These practices by third parties are detrimental to the effective delivery of health care. This can result in preventing the public from receiving care from the health care provider most experienced and skilled in handling the needed procedures. This ultimately translates to increased costs to the consumer and a lower quality of health care.

Degree Recognition

Oral and maxillofacial surgeons have a long history of providing care for trauma (See Attachment 1). Yet, over the years, other oral and maxillofacial surgeons have encountered health plans that limit our participation or reimbursement because we have a dental degree and not a medical degree. For instance, there are plans which cover treatment for a fractured jaw, but only when the services are provided by an M.D., even though it is a procedure for which we are trained and licensed.

Oral and maxillofacial surgeons have also been discriminated against by plans that permit a non-M.D., such as an oral and maxillofacial surgeon, to provide treatment, but then reimburses the provider at a differing rate because of their academic degree. This arbitrary

distinction has nothing to do with the provider's ability or experience and therefore should not be permitted. We believe that no health care reform legislation should permit managed care plans to discriminate against health care providers, in the areas of participation or reimbursement, because they hold or do not hold one type of academic degree. This problem is widely recognized at the state level, where 46 states have enacted legislation prohibiting discrimination based on the academic degree of the provider.

This concept of equality between oral and maxillofacial surgeons and M.D.s, and prohibiting degree of provider discrimination is endorsed not only by the AAOMS, but by the Medicaid and Medicare systems with their adoption of a physician definition that includes oral and maxillofacial surgeons, and by 46 states. In implementing the Resource Based Relative Value Scale in the Medicare payment system, the 1989 Omnibus Budget Reconciliation Act dictated equal payment for the same service regardless of provider academic degree. That mandate has been specifically and repeatedly endorsed by Congress, the Physician Payment Review Commission, the Health Care Financing Administration and Harvard during the past five years (See Attachment 2).

Degree of Provider Protection and The Health Security Act

As proposed, the Health Security Act recognizes the importance of prohibiting degree of provider discrimination. Its definition of health care providers and health professional services encompasses individuals legally authorized by states to deliver health care services. By not distinguishing between M.D.'s and other health care providers, the Act would prohibit some forms of discrimination. In addition, the Act prohibits health alliances and health care plans from discrimination against the mix or anticipated need for health professionals.

However, by not explicitly prohibiting degree of provider discrimination, the Administration's proposal does not adequately address our concerns.

We believe the Health Security Act of 1993 should prohibit state, regional or corporate health alliances or other plans from discriminating in employment, contracting, participation, reimbursement, or indemnification against a doctor of dental surgery or of dental medicine who is acting within the scope of the dentist's professional license under applicable State law, solely based on the academic degree of the provider.

This language does not require a plan to reimburse oral surgeons or any type or category of provider. Moreover, the language would not prohibit a plan from limiting the number and type of health care providers, and would not require that any additional or related services be covered. Rather, the language merely prohibits a plan that already provides coverage for certain services (e.g. surgery for a jaw fracture as a result of an automobile accident) from discriminating against an oral or maxillofacial surgeon solely because he or she is a dentist who is licensed to perform such services and not a medical doctor.

Hospitalization of Patients

As oral and maxillofacial surgeons, we, like other doctors, have patients who vary in their physical condition, medical history and pain tolerance. To provide our patients with the highest quality of care, the least amount of risk or discomfort, we must have the authority to hospitalize patients when their medical condition so dictates. This authority currently exists in virtually all U.S. hospitals accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

We believe that the needs of the patient and the experience, training, and ability of the health care provider should be the critical factors that determine plan participation and reimbursement policies. Our specialty is unique in its training curriculum and its scope. We bridge the disciplines of dentistry and medicine. Our scope of practice encompasses dental and medical procedures, and although the distinction between which procedures fall under what heading is at times clear cut, at times there exists a significant overlap. Oral and maxillofacial surgeons complete dental school, at least an additional four years of residency, and have clinical experience in medicine, surgery and anesthesia. (See Attachment 3).

As surgeons, nearly all of us work in a hospital setting, and are subject to each hospital credential committee's high and stringent standards that are based on the JCAHO. Education, training, experience and quality assurance ensure that patients receive the best care from the best qualified individuals.

III. COVERAGE OF ORAL AND MAXILLOFACIAL SURGERY SERVICES

Obviously, the issue of cost will likely determine what is included in the final version of any health care reform legislation. At this time, the AAOMS does not have sufficient information on the parameters of the Health Security Acts benefit plan to provide the Subcommittee with specific recommendations on which oral and maxillofacial surgery

procedures should be covered. However, we have reviewed the provisions of the Administration's proposal and believe the following critical procedures performed by oral and maxillofacial surgeons should be considered as included in the plan's comprehensive benefit package:

1. Anesthesia

The specialty of OMS pioneered the delivery of outpatient anesthesia, over forty years ago. Through a continuous process of refinement of existing techniques and the adoption of new procedures, fully 75 percent of OMS care is now delivered in the outpatient setting. Sedation and general anesthesia form the cornerstone of our ability to provide this public service. We believe that this medical service should be included in any basic health care package.

2. Birth Defects, Growth, and Development Problems

We subscribe to the notion that there is little as important as providing optimum care to the young among us. We therefore believe that any congenital defects must be addressed as expertly and expeditiously as possible so that all can become fully participatory in our society.

An example of some of these defects are cleft lip and/or palate, facial clefts, hyperplasia, hypoplasia, aplasia, neoplasia, hypertelorism, dystopia, Crouzon's syndrome, Apert's syndrome, Treacher-Collins syndrome, or identified by other descriptive terminology.

Similarly, we adhere to the belief that those among us who suffer growth and development problems resulting in not just stunted physical development be granted the same opportunity of care.

Our ability to correct the function of the facial skeleton as well as the correction of hard and soft-tissue deficiencies secondary to congenital and acquired defects should be an integral part of any basic health plan.

3. Trauma

Trauma remains a major health and social issue in the United States. Every year, hundreds of thousands of people of all ages sustain facial injuries from automobile and bicycle accidents, athletic activities, or altercations. Many of these injuries are maxillofacial fractures - fractures of the lower jaw, upper jaw, palate, cheek bones, nasal bones, bones surrounding the eyes, or combinations of these types of facial fractures.

Our involvement in facial trauma is all inclusive. Such facial trauma all too often causes significant oral disruption resulting at times in serious interference with one's ability to masticate, swallow, breath, smell and see. Treatment of these patients often requires hospitalization and the skills of professionals trained in trauma management. The patient may have chronic pain, and those with extensive residual defects frequently become emotionally impaired. Due to tissue loss, subsequent reconstructive procedures are often necessary to allow the patient to re-enter society expeditiously and fully functional.

The principles of treatment of a facial fracture are the same as for a fractured arm or leg. The parts of the bone must be aligned (reduced) and held in position (fixed, stabilized) long enough for healing to occur. This may require six weeks or more, depending upon the patient's age and the complexity of the fractures. When fractures are extensive, multiple incisions to expose bones in order to employ a combination of reduction and fixation techniques (e.g., wiring or plating) may be needed.

4. Pathology

Pathology of the maxillofacial region includes tumors, both malignant and benign, and infections of odontogenic (dental) and non-odontogenic origin. Pathology also includes disorders of the temporomandibular joint, which often result in severe pain and dysfunction. The disabilities resulting from a dysfunction of this joint are no different than those emanating from joints anywhere else in the body. Again, the reconstruction of any anatomical disruption resulting in dysfunction is an indivisible part of therapy.

Finally, we endorse the view that reconstruction of deformities or disease conditions resulting from prior surgery should be treated the same as other surgical to or therapeutic procedures.

IV. CONCLUSION

Oral and maxillofacial surgeons also perform other outpatient dental procedures, which are normally covered under dental insurance policies, and are not included in our recommendations for health care reform.

The AAOMS is currently evaluating the development of a more specific list of prioritized OMS services. Such a list could be relevant to the determination of which OMS procedures should be included in a standard benefit package. As Congress proceeds in its deliberations of any health care reform legislation, including the Health Security Act of 1993, the AAOMS will be available to discuss the specific details of the health care plan with the members of the Ways and Means Subcommittee on Health.

If you desire any further information, please contact the Association:

American Association of Oral and Maxillofacial Surgeons
9700 West Bryn Mawr Avenue
Rosemont, Illinois 60018
708/678-6200
Fax: 708/678-6286

Doctor Daniel Lew, D.D.S., President and Chairman of the Board
Mr. Jeff Flood, Executive Director
Mr. James M. Drinan, Director, Health Care and Government Relations



American Association of Oral
and Maxillofacial Surgeons

9700 West Bryn Mawr Avenue • Rosemont, Illinois 60018-5701 • 708/678-6200 • 1/800/822-6637 • FAX 708/678-6286

Daniel Lew, DDS
President

ADDITIONAL MATERIALS AVAILABLE REGARDING TESTIMONY OF THE AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

*Committee on Ways and Means, Subcommittee on Health Hearing on
Health Care Reform: The President's Health Care Reform Proposals
November 15, 1993*

- Military Medicine, "Maxillofacial Injuries Sustained in the Vietnam Conflict"; September, 1969.
- Amended 1987 definition of physician from the Social Security Act.
- Excerpts from the 1990 Physician Payment Review Commission's Annual Report to Congress
- Excerpt from the November 25, 1991 Federal Register with comments on relative value payment scales for nonphysician practitioners.
- The American Dental Association's Commission on Dental Accreditation "Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery"

These materials are available FREE OF CHARGE by simply calling AAOMS
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PHYSICIAN PAYMENT REVIEW COMMISSION
ANNUAL REPORT TO CONGRESS--1990

CHAPTER 9

PAYMENT TO LIMITED LICENSE PRACTITIONERS

Under the Omnibus Budget Reconciliation Act of 1989, Medicare will pay for physicians' services under a fee schedule based on resource costs. This fee schedule will apply not only to doctors of medicine (MDs) and osteopathy (DOs) but to limited license practitioners (LLPs) defined as "physicians" under the Medicare statute, specifically, as:

- o doctors of dental (oral) surgery or dental medicine,
- o doctors of podiatric medicine,
- o doctors of optometry, and
- o chiropractors meeting certain educational and licensing standards.

Because Congress has resolved the issue of whether limited license practitioners should be incorporated into the fee schedule, this chapter reflects the Commission's thinking on how that should be accomplished. The chapter begins with a review of current Medicare policies affecting payment to LLPs. It then describes the practice characteristics and professional training for each of the four types of practitioners and analyzes Medicare charge data for their services. The chapter concludes with a discussion of the Commission's recommendations for payment of LLPs under the Medicare Fee Schedule. Although other concerns about Medicare policy related to LLPs, such as service coverage and competency to perform specific services, have been raised, this chapter focuses on payment.¹

RECOMMENDATIONS

The principle stated in the Commission's 1989 report that physicians should be paid the same when the service is the same should apply to all practitioners defined as physicians under the Medicare statute.

¹ Other issues related to limited license practitioners, including Volume Performance Standards and practice guidelines, are discussed in Chapter 11.

Oral and maxillofacial surgeons should be paid under the Medicare Fee Schedule, using the same relative values and conversion factors as applied to doctors of medicine and osteopathy.

Because less is known about whether podiatrists and optometrists provide the same services as doctors of medicine and osteopathy when they bill under the same procedure codes, the Commission will conduct additional analyses this year to make recommendations on how to pay these practitioners under the Medicare Fee Schedule.

Because of difficulties in linking chiropractic services into the Medicare Fee Schedule, a separate budget neutral fee schedule that incorporates a geographic adjustor should be constructed for the single chiropractic service covered by Medicare.

CURRENT PAYMENT TO LIMITED LICENSE PRACTITIONERS

Currently, Medicare makes no distinction between LLPs and MDs in implementing payment. Both types of practitioners are paid on the basis of customary, prevailing, and reasonable (CPR) charges for covered services falling within state scope of practice laws.² The Participating Physician and Supplier Program (PAR) and maximum allowable actual charge (MAAC) limits apply to LLPs in the same manner as to MDs and DOs.

The discretion granted to carriers in setting Medicare prevailing charges by specialty extends to limited license practitioners. Most carriers, particularly those recognizing a wide range of MD specialties, develop separate prevailing charge profiles for limited license practitioners. Other carriers group oral surgeons with surgical specialties. Podiatrists and optometrists may be grouped with surgeons, general practitioners, or other nonspecialists.³

Limited license practitioners other than chiropractors use many of the same procedure codes as MDs and DOs. Although LLPs may account for a large percentage of allowed charges for certain codes, there is considerable overlap between their practice and that MDs and DOs. There are also special HCFA Common Procedure Coding System (HCPCS) codes for some LLP services not found in the Current Procedural Terminology (CPT4) manual (for example, chiropractic manipulation and routine foot care).

² Podiatrists, dentists, optometrists, and chiropractors are distinguished from other health professionals by inclusion in the definition of physician. Other providers, most notably nurse-midwives and psychologists, are not defined as physicians even though their services may be reimbursed when provided (in some cases) without physician supervision. Similarly, other limited license practitioners, such as audiologists and physical therapists, may sign participation agreements but are not considered physicians.

³ Specialty differentials per se do not apply to chiropractors because they do not bill for the same services as MDs and DOs. There is considerable variation, however, in the specialty designations assigned to chiropractors. Some carriers group chiropractors with nonspecialists and general practitioners. Others, including many that do not use specialty differentials for payment to medical doctors, identify chiropractors separately.

PRACTICE CHARACTERISTICS, TRAINING, AND MEDICARE CHARGES

This section describes the practices and training of limited license practitioners and presents analyses of Medicare charges for their services, specifically:

- o Medicare-covered services falling within their scopes of practice,
- o the extent and nature of their professional training,
- o services accounting for a substantial proportion of their Medicare charges,
- o the distribution of charges between LLPs and other physician specialties for overlapping services, and
- o a comparison of average allowed charges for overlapping services.

Podiatrists

Podiatrists are trained and licensed to deliver a wide range of services, including medical and surgical treatment of diseases of the skin and nails, corns, callouses, bunions, bursitis, and foot injuries affecting bones, tendons, muscles, and joints. They also prescribe and administer drugs, physical therapy, and corrective devices. In 1987, allowed charges for Medicare podiatry services totaled \$433 million, or 1.8 percent of the total for Part B physicians' services.

Podiatrists receive four years of post-baccalaureate education.⁴ The first two years are devoted to classroom instruction and laboratory sessions in basic sciences including anatomy, physiology, microbiology, biochemistry, pharmacology, and pathology. The third and fourth years are devoted to clinical training in diagnosis (history taking, physical examination, clinical lab procedures, and diagnostic radiology); therapeutics (physical medicine, orthotics, and prosthetics); surgery; and anesthesia. Most graduates pursue one- to two-year hospital-based residency programs.

There is considerable variation across states in podiatric practice. Some states, including Arizona, Georgia, Idaho, and Nevada, define podiatry to include the leg as well as the foot. Others, such as California, Ohio, and Pennsylvania, limit treatment beyond the foot to those muscles and tendons of the leg that govern the foot. In Hawaii, podiatrists may treat feet surgically but legs only medically.

Medicare payment to podiatrists is concentrated on three types of services: surgical procedures involving the foot, office visits, and diagnostic radiology (Table 9-1). These services are also commonly provided by orthopedic and general surgeons, general and family practitioners, internists, dermatologists, and radiologists (Table 9-2). For many of these services, podiatrists account for more than half of total allowed charges.

⁴ Although a minimum of three years of college education is required prior to matriculation, 95 percent of entering podiatry students have earned a bachelor's degree.

Table 9-1. Procedure Codes Accounting for the Top 70 Percent of Allowed Charges for Podiatrists, 1987

HCPCS Code	Description	Percent of Allowed Charges
11750	Removal of Nail Bed	6.4
11710	Surgical Cleansing of Nails	4.5
90050	Office Visit, Limited	4.2
11700	Surgical Cleansing of Nails	4.0
TJ060	Routine Foot Care	3.8
28285	Revision of Hammertoe	3.7
11730	Removal of Nail Plate	3.7
73620	X-Ray Exam of Foot	3.6
90060	Office Visit, Intermediate	3.4
10100	Drainage of Infected Nail	3.2
28292	Correction of Bunion	3.0
10060	Drainage of Skin Abscess	2.6
11000	Surgical Cleansing of Skin	2.6
11701	Surgical Cleansing of Nails	2.6
73630	X-Ray Exam of Foot	2.4
90040	Office Visit, Brief	2.4
90015	Office Visit, New, Intermediate	2.4
11711	Surgical Cleansing of Nails	2.1
20600	Drainage Joint/Bursa/Cyst	1.6
93910	Lower Limb Artery Study	1.6
28296	Correction of Bunion	1.3
90010	Office Visit, New, Limited	1.2
11040	Surgical Cleansing, Abrasion	1.0
28293	Correction of Bunion	0.9
28214	Partial Removal of Toe	0.9
28308	Incision of Metatarsa	0.9
28270	Release of Foot Contracture	0.8
28153	Partial Removal of Toe	0.8
10101	Drainage of Infected Nail(s)	0.7
20605	Drainage Joint/Bursa/Cyst	0.7
Total		72.3

Source: BMAD Provider File.

Table 9-2. Distribution of Allowed Charges for Services Provided by Podiatrists and Other Physicians, 1987

HCPCS Code	Description	Percent of Charges by Podiatrists	Specialty Accounting for Substantial Portion of Charges (Percent of Charges)
90060	Office Visit, Intermediate	1	Internal Medicine (38)
90050	Office Visit, Limited	2	Internal Medicine (34)
90040	Office Visit, Brief	4	Internal Medicine (25)
90010	Office Visit, New, Limited	10	Orthopedic Surgery (13)
90015	Office Visit, New, Intermediate	10	Internal Medicine (15)
93910	Lower Limb Artery Study	16	General Surgery (35)
20605	Drainage of Joint/Bursa/Cyst	28	Orthopedic Surgery (25)
73630	X-Ray Exam of Foot	42	Radiology (28)
11040	Surgical Cleansing/Abrasion	62	General Surgery (16)
20600	Drainage of Joint/Bursa/Cyst	63	Orthopedic Surgery (10)
11000	Surgical Cleansing of Skin	66	General Surgery (17)
73620	X-Ray Exam of Foot	72	Orthopedic Surgery (12)
28296	Correction of Bunion	69	Orthopedic Surgery (28)
10060	Drainage of Skin Abscess	74	General Surgery (7)
28292	Correction of Bunion	76	Orthopedic Surgery (28)
28293	Correction of Bunion	78	Orthopedic Surgery (20)
28285	Revision of Hammertoe	84	Orthopedic Surgery (14)
11750	Removal of Nail Bed	87	General Surgery (4)
28308	Incision of Metatarsal	89	Orthopedic Surgery (10)
28270	Release of Foot Contracture	93	
11730	Removal of Nail Plate	93	
10100	Drainage of Infected Nail	97	
28153	Partial Removal of Toe	97	
11700	Surgical Cleansing of Nails	97	
10101	Drainage of Infected Nail	97	
11710	Surgical Cleansing of Nails	99	
11701	Surgical Cleansing of Nails	99	
71060	Routine Foot Care	99	
11711	Surgical Cleansing of Nails	99	

Source: BMAD Provider File.

Table 9-3. Average Allowed Charge By Specialty for Services Provided by Podiatrists, 1987

HCPCS Code	Description	Podiatry	Avg Charge All MDs	Ortho Surg	Gen Surg	Gen Pract	Family Pract	Int Med	Derm
10060	Drainage of Skin Abscess	\$32	\$33	—	\$40	\$29	\$29	\$33	—
11000	Surgical Cleansing of Skin	28	48	—	61	29	—	53	32
11040	Surgical Cleansing, Abrasion	28	33	—	38	26	24	35	31
11750	Removal of Nail Bed	149	89	—	89	—	—	—	—
20600	Drainage of Joint/Bursa/Cyst	40	26	26	—	—	21	26	—
20605	Drainage of Joint/Bursa/Cyst	36	28	28	—	27	26	29	—
28292	Correction of Bunion	508	486	486	—	—	—	—	—
28293	Correction of Bunion	593	549	549	—	—	—	—	—
28296	Correction of Bunion	617	587	587	—	—	—	—	—
28308	Incision of Metatarsal	293	301	301	—	—	—	—	—
90010	Office Visit, New, Limited	31	28	31	26	26	25	30	32
90015	Office Visit, New, Intermediate	30	34	37	31	30	30	38	36
90040	Office Visit, Brief	21	16	18	16	15	15	18	19
90050	Office Visit, Limited	22	20	22	20	18	18	22	22
90060	Office Visit, Intermediate	25	25	27	23	22	22	27	27
93910	Lower Limb Artery Study	134	86	—	75	—	144	99	—
Weighted Average, Above Services		41	38	—	—	—	—	—	—

Source: BMAD Provider File.

Average allowed charges for these services vary across specialties (Table 9-3), although there is no consistent pattern. In some cases, podiatrists are paid considerably more than other physician specialties; in others, they are paid the same or less.

Oral and Maxillofacial Surgeons

While dental services are not covered by Medicare,² doctors of dental surgery or dental medicine may receive payment for other services. These include surgery related to the jaw or contiguous structures, reduction of jaw or facial bone fractures, dental examinations necessary to detect infections prior to surgery, treatment of oral infections, and interpretation of diagnostic X-rays in connection with other covered services.

² Medicare defines dental services as the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth.

Dentists specializing in oral and maxillofacial surgery receive four years of residency training beyond the four-year post-baccalaureate D.D.S. degree. The curriculum includes instruction in basic sciences and physical diagnosis as well as rotations in anesthesia, surgery, and internal medicine.

Services provided by oral surgeons accounted for only \$11 million, or 0.05 percent, of Part B allowed charges for physicians' services in 1987. While their services account for a substantial proportion of allowed charges for a small set of procedure codes (Table 9-4), this set of procedure codes does not account for a substantial proportion of charges by oral surgeons to Medicare beneficiaries. The top 90 percent of oral surgery allowed charges is distributed among 187 codes (Table 9-5).⁶

Table 9-4. Distribution of Allowed Charges by Specialty for Services Provided by Oral and Maxillofacial Surgeons, 1987

HCPCS Code	Description	Percent of Oral Surgeons	Specialty Accounting for Substantial Portion of Charges (Percent of Charges)
11100	Biopsy of Lesion	0.3	Dermatology (81)
11442	Removal of Skin Lesion	0.8	Dermatology (51)
15120	Skin Split Graft Procedure	2	Plastic Surgery (35)
41112	Excision of Tongue Lesion	24	Otolaryngology (49)
40814	Excise/Repair Mouth Lesion	45	Otolaryngology (29)
21499	Head Surgery Procedure	47	Otolaryngology (17)
40808	Biopsy of Mouth Lesion	48	Otolaryngology (35)
21210	Face Bone Graft	48	Plastic Surgery (25)
21462	Repair Lower Jaw Fracture	53	Otolaryngology (18)
40812	Excise/Repair Mouth Lesion	56	Otolaryngology (20)
21470	Repair Lower Jaw Bone Fracture	57	Otolaryngology (17)
21455	Repair Lower Jaw Fracture	60	Otolaryngology (18)
21200	Reconstruct Lower Jaw Bone	65	Otolaryngology (12)
40810	Excision of Mouth Lesion	68	Otolaryngology (16)
21041	Removal of Jaw Bone Lesion	69	Otolaryngology (12)
70355	Panoramic X-Ray of Jaw Joints	70	Radiology (20)
21215	Lower Jaw Bone Graft	71	Otolaryngology (12)
21030	Removal of Face Bone Lesion	75	General Surgery (4)
21242	Reconstruction of Jaw Joint	76	General Surgery (5)
21040	Removal of Jaw Bone Lesion	79	Otolaryngology (5)
41899	Gum Surgery Procedure	82	Otolaryngology (11)
21240	Reconstruction of Jaw Joint	83	General Surgery (5)
40845	Reconstruction of Mouth	84	General Surgery (8)

Source: BMAD Provider File.

⁶ By contrast, 16 procedures account for 90 percent of allowed charges by optometrists (Table 9-7).

Table 9-5. Procedure Codes Accounting for Top 50 Percent of Allowed Charges for Oral and Maxillofacial Surgeons, 1987

HCPCS Code	Description	Percent of Allowed Charges
21240	Reconstruction of Jaw Joint	3.7
21470	Repair Lower Jaw Bone Fracture	3.5
21215	Lower Jaw Bone Graft	3.1
70355	Panoramic X-Ray of Jaws	2.8
21040	Removal of Jaw Bone Lesion	2.8
21030	Removal of Face Bone Lesion	2.5
90600	Limited Consultation	2.2
21041	Removal of Jaw Bone Lesion	2.1
90050	Office Visit, Limited	2.1
41899	Gum Surgery Procedure	1.8
21499	Head Surgery Procedure	1.8
21243	Reconstruction of Jaw Joint	1.5
40812	Excise/Repair Mouth Lesion	1.5
21455	Repair Lower Jaw Fracture	1.3
21200	Reconstruct Lower Jaw Bone	1.3
90015	Office Visit, New, Intermediate	1.2
40845	Reconstruction of Mouth	1.2
40810	Excision of Mouth Lesion	1.2
90020	Office Visit, New, Comprehensive	1.1
40808	Biopsy of Mouth Lesion	1.1
21462	Repair Lower Jaw Fracture	1.1
90620	Comprehensive Consultation	1.1
21210	Face Bone Graft	1.1
11100	Biopsy of Lesion	1.0
11442	Removal of Skin Lesion	1.0
90060	Office Visit Intermediate	0.9
90605	Intermediate Consultation	0.9
41112	Excision of Tongue Lesion	0.9
40814	Excise/Repair Mouth Lesion	0.9
90610	Extended Consultation	0.8
15120	Skin Split Graft Procedure	0.8
90010	Office Visit, New, Limited	0.8
Total		50.1

Source: EMAD Provider File.

Oral surgeons bill for many of the same codes as otolaryngologists, general and plastic surgeons, and in some cases, radiologists (Table 9-4). Some variation exists in average allowed charges across these specialties (Table 9-6). These figures should be viewed with caution, however, due to the small number of services provided by each specialty for a given procedure code.

Table 9-6. Average Allowed Charge by Specialty for Services Provided by Oral and Maxillofacial Surgeons, 1987

HCPCS Code	Description	Oral Surgery	Average Charge		Gen Surg	Plastic	
			All MDs	Otolaryngology		Surg	Derm
11100	Biopsy of Lesion	\$49	\$43	—	\$42	—	\$43
11442	Removal of Skin Lesion	97	80	98	89	110	72
15120	Skin Split Graft Procedure	466	477	433	415	545	630
40808	Biopsy of Mouth Lesion	52	47	47	52	—	—
40810	Excision of Mouth Lesion	99	72	68	83	—	—
40812	Excise/Repair Mouth Lesion	92	96	95	99	—	—
41112	Excision of Tongue Lesion	154	182	183	175	—	—
90010	Office Visit, New, Limited	21	30	31	26	28	32
90015	Office Visit, New, Intermediate	29	34	35	31	32	36
90020	Office Visit, New, Comprehensive	44	42	41	44	43	41
90050	Office Visit, Limited	20	20	21	19	21	22
90060	Office Visit, Intermediate	24	25	25	23	26	27
90600	Limited Consultation	34	42	42	42	35	43
90605	Intermediate Consultation	41	50	49	50	46	50
90610	Extended Consultation	49	61	58	62	54	58
90620	Comprehensive Consultation	64	80	75	82	76	76
Weighted Average, Above Services		41	44				

Source: BMAD Provider File.

Optometrists

Optometrists are trained to test visual acuity; to detect eye diseases and ocular manifestations of other systemic diseases; and to prescribe corrective lenses and therapy to preserve or restore visual performance. All 50 states now permit optometrists to use diagnostic drugs; 25 allow optometrists to use and prescribe therapeutic drugs.

The Doctor of Optometry is a four-year degree program that includes training in basic medical sciences, ocular science (anatomy, neuroanatomy, and neurophysiology of the

Chiropractors

Unlike other limited license practitioners, Medicare requires that chiropractors meet minimum educational standards in order to receive Part B payment. These standards prescribe the length of both pre-professional and chiropractic education and appropriate curricula. Chiropractors seeking Medicare payment are further required to pass state chiropractic examinations and to be at least 21 years of age.

Chiropractic colleges offer a four-year curriculum to students who have completed at least two years of college. Among entering students, 13 percent have associate degrees and 35 percent have bachelor's degrees. During the first two years of chiropractic training, students receive instruction in basic sciences (anatomy, physiology, chemistry, nutrition, pathology, and hygiene) and clinical sciences including diagnosis, chiropractic principles, and X-ray. The second two years are devoted to clinical practice in diagnosis and treatment, with approximately half of the time spent in clinics.

Medicare covers only one chiropractic procedure, manual manipulation of the spine to correct a subluxation demonstrated by X-ray (HCPCS code A2000). In 1987 allowed charges for this one code were \$134 million, or 0.5 percent of the total for Part B physicians' services.

THE COMMISSION'S APPROACH

The Commission's recommendations in its 1989 report to Congress to eliminate specialty differentials and to exclude from the relative value scale a factor for the opportunity costs of specialty training were based on the principle that physicians should be paid the same when the service is the same. This principle suggests that when the services of LLPs are the same as those provided by MDs and DOs, the payment should be the same.

As mentioned previously, Medicare now applies the same CPR methodology to determine payment for LLPs and MDs. These four LLP specialties are distinguished from other non-MD health professionals by inclusion in the definition of physician. Further, those carriers that do not use specialty differentials generally group LLPs with MDs. Those carriers that do make specialty distinctions group some LLPs with certain MD specialties.

Although charge data do not always provide an accurate guide to relative costs, they are relevant for assessing the likely impact of policy changes. Analysis of charge data indicates that podiatrists and oral surgeons are generally paid the same as MDs for those procedures that both groups provide, but optometrists are paid somewhat less than MDs for overlapping services.

There are a number of dimensions on which the services of LLPs and MDs might differ. These include resource costs and clinical content. For example, LLPs may spend more or less time in providing a given service. No data currently exist, however, that permit direct analysis of these issues. The Commission will develop such data this coming year to allow it to make more informed decisions.

Because limited license practitioners are heterogenous in terms of training, practice characteristics, and the extent to which their services overlap with MDs and DOs, the Commission has chosen to make separate recommendations for each LLP specialty. Underlying all of these recommendations, however, is the principle that payment should be the same when the service is the same.

RECOMMENDATION

The principle stated in the Commission's 1989 report that physicians should be paid the same when the service is the same should apply to all practitioners defined as physicians under the Medicare statute.

Because oral and maxillofacial surgeons were surveyed by Hsiao in his Phase I study, the Commission already has resource-based relative values for their services. In addition, cross-specialty links have been established that permit comparison of intraservice work between oral and maxillofacial surgeons and MD specialties. One family of oral surgery codes, irrigation and exploration of maxillary sinuses (CPT codes 31000-31033), was included in the Commission's reference fee schedule submitted to the Congress in late 1989.⁸

RECOMMENDATION

Oral and maxillofacial surgeons should be paid under the Medicare Fee Schedule, using the same relative values and conversion factors as applied to doctors of medicine and osteopathy.

Information about resource costs for services billed by LLPs under the same procedure codes as those used by MDs and DOs could be used to assign relative values for some

⁸ See Physician Payment Review Commission, *Services and Procedures for Initial Transition Step to a Medicare Fee Schedule*, prepared at the request of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, September 21, 1989.

services provided by podiatrists and optometrists.⁹ But less is known about these services and whether or not they differ from those provided by MDs and DOs. A number of Commission activities already underway should yield more information about these services. For example, in the case of evaluation and management (EM) services, the participation of both podiatry and optometry in advisory panels on EM coding related to the EM coding consensus processes should improve knowledge about the content of visits provided by these practitioners. There will be opportunities to compare many technical procedures provided by LLPs to those provided by MDs and DOs as part of the relative value scale (RVS) refinement process.¹⁰ Visit pattern data collected to develop relative values for specific surgical global services may be useful in comparing services between podiatrists, orthopedists, and dermatologists.

Each of these sources is likely to shed light on whether LLPs are providing the same services when they bill under the same codes as their MD/DO counterparts. The Commission intends to pursue additional activities to address this question by convening focus groups to investigate similarity in services and possibly by developing estimates of relative work by these providers.

The results of these studies could lead to two different conclusions. The Commission may find that some procedure codes represent different services to different practitioners. These differences could then be accommodated by changes in coding.¹¹ For other codes, the Commission may find that LLPs and MDs provide similar services. In that case, they should be paid the same amount. Nevertheless, additional work may be necessary to refine relative values for procedures in which LLPs dominate (for example, surgical cleansing of nails) so that estimates of time and work are valid. This input could be obtained via surveys, through consensus panels, or from specialty societies. The Commission anticipates that these issues will be resolved well before implementation of the fee schedule in 1992.

⁹ Work values for a number of services provided by podiatrists are available through Hsiao's surveys of orthopedic surgeons and dermatologists. Similarly, work values for some optometry services are available through Hsiao's survey of ophthalmologists.

¹⁰ The RVS refinement process will allow review of the accuracy and reasonableness of relative work values assigned to technical procedures and will provide opportunities to identify and comment on work values that appear unreasonably high or low.

¹¹ It has been suggested that the perception that limited license practitioners provide the same services as MDs and DOs may be an artifact created by the HCPCS coding system. Although CPT codes were developed to characterize services provided by medical doctors, the Health Care Financing Administration has adopted CPT for all Medicare-defined physicians.

RECOMMENDATION

Because less is known about whether podiatrists and optometrists provide the same services as doctors of medicine and osteopathy when they bill under the same procedure codes, the Commission will conduct additional analyses this year to make recommendations on how to pay these practitioners under the Medicare Fee Schedule.

The Commission has further determined that for those specialties whose practices do not overlap the practices of MDs and DOs, a unique fee schedule should be created. In the case of chiropractors, only one service, spinal manipulation (HCPCS code A2000), is covered by Medicare. This code is used exclusively by chiropractors.

RECOMMENDATION

Because of difficulties in linking chiropractic services into the Medicare Fee Schedule, a separate budget neutral fee schedule that incorporates a geographic adjustor should be constructed for the single chiropractic service covered by Medicare.

Mr. LEWIS. Dr. Harper.

**STATEMENT OF HAZEL J. HARPER, D.D.S., CHAIRPERSON,
LEGISLATIVE COMMITTEE, NATIONAL DENTAL ASSOCIATION**

Dr. HARPER. Good afternoon, and thank you for allowing us the opportunity to testify here. My name is Dr. Hazel Harper, and I am the Legislative Chairperson for the National Dental Association.

Not to reiterate on some of what my colleagues have already said, I would just like you to know from our standpoint that we are gratified that in the current health plan there is inclusion of dental care. However, we would like to stress the fact that access to care is limited for high-risk groups and that the current public health and Federal programs are woefully inadequate.

For those of us who believe that health care should be a right for all, we also believe that a serious approach to providing health care to the underserved is an active and not a passive health care system and that the system must identify with its service population and outreach to its residents in a way that is culturally relevant.

Along those lines, I would like to share with you that I was a freshman dental student at Howard University in 1971. It was the "post" Great Society era, soon after the passage of the Medicare and Medicaid legislation, and we felt there was great promise and hope for public health and for the indigent and underserved people of this country.

Now, almost 30 years afterward, I have moved into the mainstream of practitioners for the underserved in this country, and I realize that there is still an awful lot that has not been done and that, in some areas, the disparity in health care is even greater now than it was in the past.

So I asked myself what happened? What happened to the promise of the legislation that was intended to serve the needs of the underserved? Why is it that for some people there is a greater crisis in dental health care now than there was before, in spite of all the advances that we have made in modern dentistry?

We are still embarrassed by statistics of our indigent groups that resemble those of Third World and developing countries, specifically with regard to the fact that 75 percent of dental caries in children is concentrated in only 25 percent of the population, and that the 5 year survival rate for oropharyngeal cancer is only 21 percent for African-Americans as opposed to 53 percent for whites. Sealants in dentistry are now analogous to immunizations in medicine; and yet across the board for all 9- to 11-year-olds, only 18 percent of our children have sealants, 21 percent of white children, 6 percent of African-Americans, and only 10 percent of Hispanics. We realize in this country only 50 percent of the communities have water fluoridation. If we also realize that fluorides and sealants are two of the best public health measures known to mankind, why is it that only 21 percent of our children have sealants and only 50 percent of our population drinks fluoridated water?

Where did we go wrong? Because we did not improve access to dental care for the underserved. We discounted the relevancy of sexism and racism and classism in the delivery of care. We did not educate ourselves or our students to be culturally sensitive and

health-outcome oriented. We diminished the importance of community health centers, public health facilities and inner city hospitals; and we passively contributed to the dismantling of this vital infrastructure.

Most tragically, we allowed the Medicaid system to strip away dignity and equity, create a two-tiered, class-oriented system, and disenfranchise providers and disempower program administrators by drastically slashing the funds.

We realize that our biggest challenge will be to not repeat the mistakes of the past and to do it right this time when it comes to reforming the health care system.

We want to make oral health promotion and disease prevention a priority, and we also want to make sure that we do what is necessary to reach out to the community and to educate people so that they know the ways that they can best provide health care for themselves and be more responsible and accountable for their own health care.

We also want to make sure that the inclusion of dental health care is across the board for adults is implemented in a more rapid progression, and that hopefully we do not have to wait until the year 2001 for adult dental care. But, most importantly, we want to express the fact that we understand now that the real role of minorities and all of those who are culturally sensitive to the needs of the underserved will be to be more visible, to be more vocal, and to be more vigilant so that those that serve us are held more accountable to the tasks at hand.

We thank you for allowing the NDA this opportunity to come before you.

Mr. LEWIS. Thank you, Dr. Harper.

[The prepared statement follows:]

**TESTIMONY OF HAZEL J. HARPER, D.D.S., M.P.H.
CHAIRPERSON
NATIONAL DENTAL ASSOCIATION LEGISLATIVE COMMITTEE**

The oral health care of the 150 million Americans who have no dental insurance and the millions more who are dentally underinsured, both of whom contain disproportionate large numbers of African-Americans, is comparable to the most underdeveloped countries. Access to care is limited for high risk groups, and current public health and federal programs are woefully inadequate. For those of us who champion health care as a right for all, we believe that the serious approach to providing health care to the underserved is an "active" not "passive" health care system. The system must identify with its service population and outreach to its residents in a way that reflects cultural competency.

I was a freshman dental student at Howard University College of Dentistry in 1971, five years after the enactment of the Medicaid and Medicare legislation. It was the "post" Great Society era, and we were naive and idealistic about what each of us could accomplish as health professionals in the years ahead. We hadn't the vaguest idea what the true extent of our challenge would be, nor could we have imagined what the scope of our contributions would be.

But now we know. My mentors and role models in dentistry believed they were doing the right thing in 1965. They thought they were endorsing programs for the indigent and the elderly that would give these groups the same opportunities for health and the quality of life as the rest of the country. Their goal was to elevate the health status of these groups and eliminate the disparities in health between the haves and the have-nots.

But after nearly 30 years, how have things changed? For some Americans, they have gotten worse. The disparity in health between Blacks and Whites is increasing, and the life expectancy for black males has even decreased. Many of us who lived through the exhilaration and optimism of the 1960's social revolution wonder, **WHAT HAPPENED TO THE PROMISE???**

Consider these facts:

- Four of ten people with AIDS belong to minority groups
- The death rate from stroke is 65% higher in the minority population than in the non-minority population.
- More than 1 in 5 children are poor. 1 in 2 African-Americans and Latino children are poor.
- Half of all African-American women have no private health insurance. 6 out of 7 POOR African-American women have no private health insurance.

With regard to the crisis in dental health care, we are currently witnessing the emergence of a second generation of "dental neglects." With all of the marvelous advances in modern dentistry, the fact is this country is second to none in research and development, product design and technology, and education and training. In spite of all of this, we STILL are embarrassed by statistics from our indigent groups that resemble those of third world and developing countries:

- By age 15, 91% of Native Americans and Alaska Native children have experienced dental caries.

- The level of untreated disease among minorities--especially Native Americans and Alaska Native children--is much higher than for whites.

WHERE DID WE GO WRONG?

Although a lot of people had their "heart in the right place", we made a lot of mistakes about dental health care. It was impossible for us to improve the health status of the disadvantaged and the underserved, mainly because;

- We did not improve access to dental care.
- We discounted the relevancy of racism and classism in the care and treatment of the indigent.
- We did not pay close enough attention to the attitudinal factors and behaviors of providers that created barriers and negatively affected the compliance and health outcome of patients of dissimilar culture, socio-economic status, race or gender.
- We did not educate ourselves or our students to be culturally sensitive and health outcome oriented.
- We diminished the importance of community health centers, public health facilities, and inner city hospitals, and passively contributed to the dismantling of this vital infrastructure.
- We allowed Medicaid to strip away dignity and equity; create a 2-tiered, class oriented system; disenfranchise providers and disempower program administrators by drastically slashing funds.

The biggest challenge ahead will be to not repeat the mistakes of the past. We must follow the example of organizations that are determined to revolutionize the health care system, and do it right this time. The role of minorities (and other culturally sensitive health care providers) in the health care reform process is to elevate the oral health status of the African-American and minority communities. In order to diminish the Black/White disparity in health and achieve the true goals of Health Care Reform, an effective, outcome oriented plan must be implemented which will accomplish the following:

- Cover ALL persons and provide universal access regardless of race, gender, employment status or pre-existing conditions.
- Provide basic primary oral health benefits for children and adults to include preventive services, emergency care, conservative restorative care, periodontal maintenance, and provisions for the "phase-in" of complete and partial dentures.
- Make oral health promotion and disease prevention a priority to include: community water fluoridation, sealants, protective sports equipment (mouth guards), oral cancer screening, and community outreach.
- Establish community ratings and "risk adjusted rates" for providers who treat high-risk patients (underserved,

disadvantaged, elderly, etc.), so that these providers receive higher compensation, because the costs to provide care is greater.

- Invest in community-based infrastructures in underserved areas, and provide incentives for providers in underserved areas to develop other community-based delivery alternatives.
- Provide financial incentives for providers in underserved areas, i.e., educational loan forgiveness programs, small business tax credits and other tax incentives.
- Abolish the existing Medicaid bureaucracy, privatize the administration of this federal program, improve the efficiency, increase reimbursement levels and expedite payments.
- Demonstrate through legislative mandate the commitment of the Federal Government to stimulate and assure diversity such that ethnic providers will be appropriately represented in the ownership and control of any managed care system.
- Include African-Americans and other minorities on health alliances and national governing boards such that they are represented proportionately to the percentage of underserved patients in the system.

Because we do not want the mistakes of the last two decades to continue to haunt us, we must face the fact that the Medicaid system, as we know it today, must be abolished. Oral Diseases and other oral conditions that are prevalent among children and adults must be eradicated. No person can be considered healthy when living with diseases in the mouth. What has not been effectively communicated is that tooth decay and gum disease are bacterial infections, that when left untreated, will extend far beyond the health of the mouth. The poor, underserved and unserved have a tremendous accumulation of active infectious oral diseases, which will not be helped by preventive measures alone.

Although African Americans were strong proponents of Medicaid and Medicare, after enactment of the legislation, these same providers were relegated to peripheral roles in terms of program administration, management and evaluation. In any new national health program, African Americans must be members of the regional and state alliances and must also be included in the National Governing Board. These alliances must have African Americans and other minorities represented proportionately to the percentage of underserved patients in the system.

In the development of any national health care policy, there can never be enough emphasis placed on the need for the inclusion of African Americans and other minorities in all phases of development, implementation, management and evaluation. From a historical perspective, despite the fact that African American practitioners have traditionally "subsidized" failing government health plans, these same practitioners have been systematically excluded from planning and management. Racism and discrimination are continuous barriers to ownership and control of health systems organizations.

Any national system of health services must include the availability of "basic" and primary dental care services to children as well as adults.

These basic primary dental care services should include:

- A. Services for children (Up to Age 18 Years)
 - 1. Diagnostic
 - 2. Preventive (including sealants, prophylaxes, fluoride treatment, sports mouth guards)
 - 3. Medically necessary orthodontic treatment (up to 21 years)
 - 4. Emergency Care
 - 5. Basic restorative care (fillings)
 - 6. Periodontal maintenance (limited scaling and root planing)
 - 7. Endodontic services
- B. Services For Adults
 - 1. Diagnostic (including oral cancer screening)
 - 2. Emergency care
 - 3. Preventive (including prophylaxes)
 - 4. Basic restorative services (filling)
 - 5. Periodontal maintenance (limited scaling and root planing)
- C. Health promotion and prevention education to include community outreach programs in churches, schools and community health centers.

The rationale for recommending this policy is that the new national health care plan should be aimed at disease prevention and disease control. Another rationale for recommending the inclusion of adult dental benefits is that low wage earners or the unemployed are unable to afford out-of-pocket costs for dental services or supplemental programs. African Americans and other minorities are disproportionately represented in these groups (poor and working poor), and bear the burden of psychosocial and economic barriers to care.

The real role of minorities in dental health reform will be to be MORE VISIBLE, MORE VOCAL and MORE VIGILANT. They must continue to form political, social and civic alliances that will be effective advocates and fervent lobbyists. They must communicate and network for change, and we must learn from the mistakes of the past. The children of America belong to ALL of us; and they deserve more. We can do better. We Must Do Better. Thank you.

REFERENCES

- (1) Jaynes, G.D. and Williams Jr., Robin M., Editors; A Common Destiny: Blacks and American Society; 1989; National Academy Press; 608 pages.
- (2) "Toward Improving the Oral Health of Americans: An Overview of Oral Health Status, Resources, and Care Delivery"; Feb., 1993 U.S. Public Health Service Oral Health Coordinating Committee.
- (3) Razzoog, M.E. and Robinson, E., Co-editors; Black Dentistry in the 21st. Century, Conference Proceedings, June 23-27, 1991, Ann Arbor, Michigan; 312 pages.
- (4) "National Health Reform and Access for Underserved Populations and Safety Net Providers: Symposium Proceedings"; February 22, 1993, Senate Hart Office Building.
- (5) African-American Prescription for Health Summit '93; Conference Proceedings, May 4-5, 1993, Washington, D.C.
- (6) National Dental Association; Statement to the Congressional Black Caucus Health Braintrust. September 18, 1993.
- (7) NDA Congressional Testimony, March 30, 1993
- (8) Colgate-Palmolive Minority Oral Health Initiative. "Bright Smiles, Bright Futures" (inner city outreach program).

Mr. LEWIS. Dr. McCaul.

STATEMENT OF BETSY MCCAUL, PH.D., DIRECTOR, COMPREHENSIVE WOMEN'S CENTER, JOHNS HOPKINS HOSPITAL, ON BEHALF OF RESEARCH SOCIETY ON ALCOHOLISM

Ms. MCCAUL. Yes, Mr. Chairman.

I am Dr. Betsy McCaul, and I am the director of the Comprehensive Women's Center at Johns Hopkins Hospital. I am here today representing the Research Society on Alcoholism. Our center is a publicly-funded substance abuse treatment program in east Baltimore and has successfully integrated treatment outcome and medication involved in research into the delivery of ongoing high quality patient care.

Today I will focus on two basic points. First is that adequate health insurance coverage for treatment of alcoholism must be included in the universal package of health care benefits. As I pointed out in my written testimony, this disease should receive coverage comparable to other diseases such as cancer, diabetes, or hypertension.

Second, a stronger commitment to research on alcohol problems is essential to ensure delivery of cost-effective care. Alcohol problems exact a devastating toll on our country in health, economic, and human terms.

More than 15 million Americans suffer from alcoholism or alcohol abuse. Alcohol consumption is associated with over 100,000 deaths every year. Untreated, alcoholism causes and contributes to a wide range of other health problems, thereby increasing use of health care services.

The economic cost of untreated alcohol problems is nearly \$100 billion a year. This figure does not include the immeasurable pain and suffering of ruined marriages, families, and careers.

Timely and effective treatment of alcoholism reduces use of expensive health care services. It is estimated that one out of every four hospitalized patients suffers from alcohol abuse. Given this high rate of alcoholism among such patients, comprehensive alcoholism treatment, not just detox services, must be covered if we are to improve the Nation's health as well as contain costs.

My second point is that a stronger commitment to research on alcohol problems is essential to the long-term success of health care reform. We have made many important advances in alcohol research, including major strides in development of medications to reduce the craving for alcohol, in our ways of matching alcoholics to the most effective treatments, and in our understanding of the mechanisms by which alcohol affects the body and brain. Ultimately, advances in treatment and prevention must come from research.

To provide adequate coverage for alcohol treatment and research, health care reform must incorporate the following three principles:

First, insurance benefits for treatment of alcohol problems should be comparable to the benefits for treatment of any other disease. Second, coverage must provide for a continuum of care. This cannot be treated as a discretionary or limited benefits. Detoxification services alone are not enough. Third, basic and applied research on this disease must be an integral part of reform, and clinical train-

ing must be provided to ensure that advances in treatment and prevention are rapidly transferred to patient care.

Thank you.

Mr. LEWIS. Thank you very much, Dr. McCaul.

[The prepared statement and attachments follow:]

STATEMENT OF THE
RESEARCH SOCIETY ON ALCOHOLISM
TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY
BETSY E. McCAUL, PH.D.

NOVEMBER 15, 1993

Mr. Chairman and Members of the Committee, my name is Mary E. McCaul, Ph.D. I am an Associate Professor in the Department of Psychiatry and Behavioral Sciences, John Hopkins University School of Medicine. The Research Society on Alcoholism (RSA) is a professional organization comprised of scientists engaged in basic and applied research, both biomedical and psychosocial, related to alcohol abuse, dependence, and addiction. Our 1,000 members are committed to addressing a panoply of issues in this important field, and they are directly and immediately concerned about the future of health care reform. RSA greatly appreciates this opportunity to appear and present testimony about the importance of including alcoholism and alcohol abuse treatment and research as essential components of reform.

As you consider alternative approaches and proposals for reforming the Nation's health care system, I urge you to recognize the impact of alcohol abuse and alcoholism in contributing to poor health and higher health care costs.

I want to make two basic points in my testimony today. The first is that adequate health insurance coverage for treatment of alcoholism and alcohol abuse disorders must be included in the package of health insurance benefits that all Americans receive. The second point is that a continued and strengthened commitment to research on alcohol problems is essential to the long-run success of the health care reform effort. The profound influence of alcohol abuse and alcoholism on the health of Americans and on the Nation's health care costs makes it imperative that these issues not be neglected in the debate over health care reform.

Consequences of Alcohol Problems

Alcoholism and alcohol abuse are pervasive health problems that exact a devastating toll on our country in health, economic, and human terms. More than 15 million Americans suffer from alcoholism or alcohol abuse, and more than half of this number are under 30 years old -- young people whose chance at a productive life free of the grip of addiction hangs in the balance. The direct effects of alcoholism on the everyday lives of its victims cannot be overstated. Quite simply, alcoholism is a disease that makes people lose control over their consumption of alcohol. We know now that this disease has no more to do with moral failings on the part of its victims than do heart disease or cancer. We have learned that genetic factors appear to predispose some individuals to a greater risk for alcohol problems than others, but that environmental elements also play a central role in allowing alcohol to take over the lives of so many -- 15 million! -- people.

The acute effects of alcohol consumption are only the first in a long list of health problems for which heavy drinking is either the cause or a significant contributing factor. These problems include both acute and chronic conditions, such as liver cirrhosis, which is the ninth leading cause of death in the United States; various cancers of the mouth and digestive tract; pancreatitis; and repeated traumatic injury, most notably that associated with automobile and boating crashes. Altogether, alcohol consumption is associated with over 100,000 deaths every

year. In addition, many nonfatal illnesses and injuries are alcohol-related.

The list of serious problems that result from alcoholism and alcohol abuse goes on from there. As many of you and many of your constituents know, alcohol problems are also family problems. Tens of millions of Americans know all too well the difficulties of family life with an alcoholic. In some of the worst cases, alcohol problems contribute to domestic violence and abuse, often with tragic consequences. For millions of others, the effects are more insidious but none the less real or damaging. Most of us know someone personally whose marriage, career, or reputation has been ruined because of alcohol problems, or whose everyday life is dominated by the realities of living with an alcoholic spouse or parent.

The alcohol problems of adults are very real problems for their children as well. Children are especially susceptible to the adverse consequences of their parents' drinking. Some children are handicapped by the turmoil of living in an abusive family. Others are saddled with the social and psychological dysfunction that may result from growing up in an alcoholic environment. Adolescents in alcoholic families may face increased risks of developing substance abuse problems of their own, perpetuating a cycle of anguish. The most tragic cases are those children who are born with the profound physical and mental impairments associated with Fetal Alcohol Syndrome.

The consequences I have been describing to you are only the most obvious damages that result from alcohol problems. More subtle but far-reaching consequences include the lost productivity that results from alcohol-related illness or early death; the potential careers wasted because of alcohol-related crime and violence; and the administrative costs that we all must pay for the social and criminal justice services that are needed because of the consequences of alcoholism and alcohol abuse. The overall cost of alcohol problems to our society in economic terms has been estimated at nearly \$100 billion dollars a year, not even counting the costs of pain and suffering that are such an important part of the damage done by alcohol problems.

Need for Treatment

I have described the damage that results from alcohol abuse and alcoholism at considerable length because I think it is important to grasp the magnitude of the problem in order to understand the importance of taking appropriate steps to limit these damages. I suggest that providing access to treatment for alcohol problems, and actually encouraging people with alcohol problems to avail themselves of such treatments, is the only responsible course.

The health effects of alcohol problems place a heavy burden on our health care system. Alcoholism both causes and contributes to other health problems and thereby increases the use of health care services. Untreated alcoholics use health care services at about twice the rate of nonalcoholics, and the families of alcoholics consume more health care services than do those of non-alcoholics. People with alcohol disorders account for between 15 and 30 percent of all hospitalized patients. Many of these are undiagnosed alcoholics being treated for the consequences of their drinking.

The weight of evidence suggests that treatment for alcoholism leads to reductions in the use of health care services. Total health care utilization and health care costs for treated alcoholics decline following treatment relative to matched non-alcoholics or to untreated alcoholics. Given the high rates of alcoholism among hospital patients, this suggests that alcoholism

treatment plays a leading role in improving the Nation's health while at the same time helping to contain health care costs. However, this dual positive role of improving health and containing costs can only be achieved if adequate coverage for treatment of alcohol problems is included in every American's basic package of health insurance benefits.

As we move toward universal health insurance, there are many good reasons to include coverage for alcohol problems in the package of insurance benefits available to all Americans, and there are no good reasons to exclude coverage for alcohol problems, including the claim that such coverage would be too costly. On the contrary, excluding coverage for alcohol problems would be far too costly.

Providing health insurance benefits for treatment of alcohol problems will not completely eliminate the adverse consequences of alcohol consumption. Many of those individuals in the greatest need of treatment will resist obtaining it; that is the nature of the disease. In addition, not everyone who receives treatment for alcohol problems recovers successfully. In this respect, alcohol problems are in the same category as most other chronic diseases. Relapse is a characteristic of many disease processes, including heart disease, cancer, arthritis, and diabetes. Indeed, a large proportion of the Nation's health care resources is devoted to the treatment of chronic, relapsing illnesses. As with these other disorders, the payoff from treatment can be measured in human and financial terms with every month of relief from the devastating effects of alcoholism.

Commitment to Research

My second main point is that a continued and strengthened commitment to research on alcohol problems is essential to the long-run success of the health care reform effort. Ultimately, our ability to reduce the devastating consequences of alcohol abuse will depend on our ability to find new and more effective ways to prevent and treat alcohol problems. Alcohol research has made many important advances, and continued investment in alcohol research holds great promise. In the crucial area of relapse prevention, for example, recent advances in pharmacotherapy raise the prospect of a medication to reduce the craving for alcohol. Other recent research attempts to match alcoholics to the most effective treatment methods on the basis of personal characteristics and to identify the most effective treatment options for referrals by employee assistance programs. Continued investment in alcohol research promises to provide clinicians with more effective tools to help prevent relapse and to sustain long-term recovery.

Basic biomedical research will bring rich dividends to our investment in human health. For example, scientists in a multisite, multidisciplinary collaborative study are working to pinpoint the location of genes that influence susceptibility to alcoholism. Success in this effort will lead to improved recognition of the potential for alcoholism in high-risk individuals. It will also contribute to our understanding of different forms of alcoholism, provide for intervention at an early stage, and open new avenues for treatment of alcohol-related problems. Other advances in basic research, such as noninvasive imaging techniques that provide a means to study the effects of alcohol on brain structures and functions, are providing unprecedented opportunities for development of more effective ways of treating and preventing alcohol problems.

Health services research is a relatively new area of research that is gaining prominence in health care reform. Studies in this area examine the effects of alternative organization, financing, and management arrangements for the delivery of health care services. Health services research focuses particularly on treatment outcomes and on the efficiency, effectiveness, and

cost-effectiveness of treatment and prevention services. Increasing our knowledge base in this area is critical to our efforts to improve the effectiveness of treatment and prevention activities while controlling the costs of health care services.

Ultimately, advances in treatment and prevention, and thus progress in reducing the costs that result from alcohol abuse and alcoholism, must come from research. Given the magnitude of the problems of alcohol abuse and alcoholism and the enormous health care costs that result directly or indirectly from alcohol disorders, increased research in this crucial area must be an integral component of any successful health care reform effort.

Principles for Health Care Reform

The need to include coverage for treatment of alcohol abuse and alcoholism in any health care reform legislation is clear. Similarly, the need for further research on alcohol disorder is indisputable. The specific benefits and research incentives will depend on the framework of the larger health care reforms enacted by the Congress. However, any health care reform legislation should reflect the following principles:

First, insurance benefits for treatment of alcohol abuse and alcohol problems should be comparable to benefits for treatment of any other disease. No special limitations should apply to alcoholism treatment beyond those that would apply to treatment of, for example, cancer or heart disease.

Second, coverage must provide for a continuum of care relating to diagnosis of, treatment for, and rehabilitation from alcohol problems. Detoxification services alone do not constitute an adequate benefit.

Third, alcoholism treatment services must not be denied nor limited on the basis of exclusions for pre-existing health conditions, including history of alcoholism or alcohol abuse.

Fourth, health care providers must be encouraged to perform routine assessments to facilitate early detection and prevention of alcohol problems.

Fifth, because denial is one of the hallmarks of alcohol disorders, health insurance provisions generally, and cost-sharing arrangements in particular, must encourage rather than discourage people with alcohol problems to initiate and to remain in treatment.

Sixth, insurance benefits must not adopt rigid definitions of covered services, since such definitions may not be appropriate for new technologies and treatments.

Seventh, basic and applied research on the causes, consequences, prevention, and treatment of alcohol problems, including health services research, must be fostered and encouraged. Advances in treatment that result from research developments must be made available to patients. This will require support for training of clinicians and other mechanisms to facilitate technology transfer.

Conclusion

The urgency of the demand for reform of our Nation's health care system presents the Congress with one the most profoundly important national policy issues of our day -- an issue that will affect the life of every American now living or yet to be born. As you proceed with this daunting task, I hope you will consider the devastating consequences of alcohol abuse and alcoholism, and the effects of these pervasive health problems on the cost of providing health care to the Nation. I urge you to insist that

any health care reform package include treatment for alcohol abuse and alcoholism as a fully covered benefit, and redoubled emphasis on basic and applied research into the causes, treatment, and prevention of alcohol problems as a key ingredient in the recipe to contain health care costs and improve the health of the Nation.

Thank you for your attention, and for the opportunity to appear and present testimony on this vital issue.

Mr. LEWIS. Ms. Weber?

STATEMENT OF ELLEN M. WEBER, CODIRECTOR OF NATIONAL POLICY, LEGAL ACTION CENTER

Ms. WEBER. Thank you, Chairman Lewis.

I am Ellen Weber, the codirector of National Policy at the Legal Action Center, which is a not-for-profit law office that focuses on drugs, alcohol, and AIDS issues.

We also staff a national coalition of state-based treatment and prevention providers that work with individuals who are in the underserved populations as well as people with private health insurance who have exhausted their benefits or who have been prohibited from basically getting into private drug and alcohol treatment programs.

We are here today to applaud the administration for including drug and alcohol treatment in the standard benefit package and in recognizing that the failure to include such coverage will neither create a healthy nor a secure environment and families. But we are also here to urge the Congress to provide a more comprehensive benefit package in the final legislation.

Trying to reform health care without providing a comprehensive benefit for drug and alcohol treatment is like trying to sail a ship with a big hole in it. The most recent data reveals that drug and alcohol problems combined cost our Nation \$166 billion in 1990. Numerous statistics reveal the direct health care costs that are increased by untreated drug and alcohol problems. These relate to HIV, AIDS, fetal alcohol syndrome, general hospital costs, and also hospital costs related to the elderly.

While the cost of untreated drug and alcohol problems is great and substantial, the cost of providing comprehensive services is minuscule. Lewin-VHI has calculated the cost of providing a comprehensive substance abuse benefit at \$45 per man, woman, and child. This would include a comprehensive range of services, from individual assessment to short-term residential care, outpatient care, and longer-term care services, including recovery homes and therapeutic communities.

While the administration has taken a critical first step in including drug and alcohol treatment, we do not believe that the benefit, as currently structured, meets several of the administration's health care principles.

First, it does not guarantee a uniform set of benefits across all plans because it has made two of the benefit levels optional. Second, it does not simplify the delivery of these services for individuals, because it combines the mental health and substance abuse package into one benefit structure, and then it implements a very complicated system of swapping residential days for either outpatient days or intensive nonresidential days.

We also have a grave concern that the benefit does not provide services to those with the most serious drug and alcohol problems. These are the so-called hard core drug users and alcohol users who the administration, in its interim drug control strategy, vowed to reach through health care reform. This package does not do that. It does not provide longer-term care, and it implements some pro-

hibitive cost sharing requirements that will literally kill individuals.

We have some recommendations to simplify and correct some of these problems. Very briefly and quickly.

To ensure that adequate coverage is provided, we would urge the Congress to separate out the substance abuse benefit from the mental health benefit and provide a comprehensive set of services. The cost of mental health services and drug and alcohol services are very, very different. They are dramatically different. And it appears that the substance abuse benefit has been artificially capped because of those mental health costs.

To the extent that a comprehensive benefit is not provided, we would urge the Congress to maintain the level of Federal and State funding for these services to ensure that individuals get appropriate and necessary care.

To improve on the cost sharing requirements, we would urge, again, that the outpatient substance abuse benefit be treated like a preventive clinic visit so that there is no cost sharing required and to ensure that the cost sharing that is required is counted to the out-of-pocket limit, which, again, is a unique and different feature applied to substance abuse services alone.

And, finally, to ensure that individuals get the appropriate care, we would urge that the utilization review and managed care systems that are put into place have regulations promulgated for them and that those regulations are monitored very carefully.

We would urge, again, that the same UR and managed care principles apply to substance abuse as well as all other health care which, again, is another unique feature in this legislation. This legislation applies different and discriminatory UR standards to substance abuse care.

Thank you for considering our views, and we look forward to working with you as this legislation is developed.

[The prepared statement follows:]

**TESTIMONY OF ELLEN M. WEBER
LEGAL ACTION CENTER**

Thank you for the opportunity to present testimony on the substance abuse benefit in the American Health Security Act. The Legal Action Center is a not-for-profit organization that specializes in the legal and policy issues related to drugs, alcohol and AIDS. We work on behalf of the individuals with these health problems and the many institutions that serve them. In addition, the Center staffs the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, a coalition of twenty state-based treatment and provider associations that serve primarily lower income individuals and those most at risk for serious drug and alcohol problems. The County Alcohol and Drug Program Administrators Association of California, California Association of Alcoholic Recovery Homes and the California Therapeutic Communities, Inc. are active members of the National Coalition. A list of the members is attached.

The inclusion of drug and alcohol treatment in the standard benefit package in the American Health Security Act is a milestone in the nation's effort to combat one of our most serious public health problems. We applaud the Administration for recognizing that a health reform bill that does not cover treatment for drug and alcohol problems will neither control costs nor create healthy, secure families.

At the same time, we believe that the substance abuse benefit as currently structured does not meet several of the Administration's health care reform principles. (See Attachment A for a description of the benefit.) The proposed benefit does not guarantee a uniform set of drug and alcohol treatment services across all health plans, and it does not simplify the delivery of these services for consumers or health professionals. In addition, we have grave concerns that the benefit will not expand services to individuals with the most serious drug and alcohol problems, the so-called "hard-core users," whom the Administration promised in its Interim Drug Strategy to reach through health care reform.¹ The benefit's length of stay limitations, cost sharing requirements and utilization review standards may dramatically limit access to services and leave the most seriously ill individuals worse off. We have included recommendations at the end of our testimony that would address these concerns.

Congress **must** include coverage for a comprehensive range of substance abuse services in the final health care reform legislation. Providing such comprehensive coverage would cost approximately \$45 per person.² Failure to do so will cost tens of thousands of lives and literally billions of dollars in health costs related to HIV/AIDS, tuberculosis, fetal alcohol syndrome and other conditions related to infant exposure to drugs, cirrhosis, emergency room admissions, accidents and other medical conditions resulting from untreated alcoholism and drug dependence. It will also contribute to violence, child abuse and other crimes, homelessness and destruction of families that plague our Nation.

¹ Office of National Drug Control Policy, Breaking the Cycle of Drug Abuse: 1993 Interim National Drug Control Strategy, September 1993 at 6-9.

² See discussion infra on p. 4-5.

A. The Need for A Drug and Alcohol Treatment Benefit

We are delighted that the Administration has included drug and alcohol treatment in its standard benefit package and has taken the significant step of removing all lifetime caps on treatment. The plan also recognizes the critical importance of integrating the current drug and alcohol treatment system into the mainstream health care system, while retaining the unique components of the treatment system that have delivered appropriate, cost effective care to hundreds of thousands of individuals and families. Specifically, it recognizes the need to retain community based treatment and to ensure that services are provided by only those entities legally authorized to do so and in the most cost-effective setting.

The decision to include drug and alcohol treatment in the standard benefit package is not only humane but also a cost saver. While some have urged the Administration and Congress to eliminate substance abuse coverage from the benefit to reduce costs, the simple truth is that eliminating this benefit would dramatically increase our Nation's health and social costs.

A recent study estimated the total cost of drug and alcohol abuse in 1990 alone to be \$166 billion, \$99 billion of which was attributed to alcohol abuse and \$67 billion to drug abuse.³ Numerous other statistics reveal the tremendous health costs that are directly linked to untreated drug and alcohol problems. Providing treatment would eliminate or dramatically reduce these costs.

- Over 32% of AIDS cases are linked to injecting drug use and 70% of all pediatric AIDS cases are linked to maternal exposure to HIV through drug use or sex with a drug user.⁴ The medical cost for treating persons with HIV/AIDS ranges from \$85,000 to \$150,000 per patient.⁵
- Between 25% and 40% of all general hospital patients are there for alcoholism-related complications.⁶ Hospital care typically costs between \$400 and \$600 per day.

³ Institute for Health Policy, Brandeis University, Substance Abuse: The Nation's No. 1 Health Problem.

⁴ National Commission on Acquired Immune Deficiency Syndrome, "The Twin Epidemics of Substance Use and HIV," 1991.

⁵ U.S. Department of Health and Human Services, Surgeon General's Report to the American Public on HIV Infection and AIDS, 1993.

⁶ Substance Abuse: The Nation's No. 1 Health Problem.

- The total annual cost of care of children born with fetal alcohol syndrome is \$1.6 billion (in 1985 dollars assuming an incidence rate of 1.9 children per 1,000 births), of which \$1.3 billion is for residential care and support services for mentally retarded persons over 21 years, \$118 million for neonatal intensive care services and \$118 million for full-time residential care for severely mentally retarded persons under 21 years.⁷
- A California study found that children who were diagnosed with substance abuse exposure problems had Medicaid expenditures almost twice the rate of Medicaid children not exposed in utero. Over 18% of the substance exposed children were born with low birth weight as compared to 7.7% of the nonexposed children.⁸
- The rate of alcohol-related hospitalizations among elderly individuals (65 years and older) is the same as the rate related to heart conditions. In 1989, hospital care for individuals with a primary alcohol diagnosis (38% of the cases) cost Medicare \$233.5 million.⁹

Untreated drug and alcohol problems also impose tremendous -- but avoidable -- costs on the foster care and criminal justice systems.

While the costs of not treating drug and alcohol problems are enormous, the costs of comprehensively treating these problems is miniscule. Lewin-VHI, Inc. has estimated the cost of a comprehensive substance abuse benefit to be approximately \$45.10 per covered life per year. Such a benefit would provide a full continuum of services, assume a 10% increase in utilization, a 50% increase in the funding per unit of service to improve the quality of care particularly in the publicly funded system, and provide lengths of stay similar to the longer lengths of stay currently provided in the publicly funded sector with an additional 10% increase in response to improve quality.¹⁰ The Legal Action Center has developed a

⁷ D.P. Rice, et al., The Economic Costs of Alcohol and Drug Abuse and Mental Illness, 1990 at 153.

⁸ M.R. Ellwood, et al., "An Exploratory Analysis of the Medicaid Expenditures of Substance Exposed Children Under 2 Years of Age in California," September 1993.

⁹ W. L. Adams, et al., "Alcohol-Related Hospitalizations of Elderly People," Jr. of the American Medical Association, Vol. 270, No. 10 (Sept. 8 1993).

¹⁰ H.J. Harwood, et al., "Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches." (Discussion Draft developed under contract for the Legal Action Center, National Association of Addiction Treatment Providers, National Association of Alcohol and Drug Counselors, National Council on Alcohol and Drug Dependence and Therapeutic Communities of America).

comprehensive treatment benefit whose cost would fit in this range. (Attachment B).

Because treatment prevents so many costly health conditions, we cannot afford the failure to include a drug and alcohol benefit in health care reform. Congress must ensure that the final health care legislation includes adequate coverage for substance abuse treatment and prevention.

B. The Need for a Stronger Substance Abuse Benefit

While the inclusion of a substance abuse benefit is a critical first step, we are very concerned that, as currently structured, the benefit will not achieve the enormous savings that it could. There are several reasons for this.

1. Lack of Adequate Coverage for Individuals Who Need Longer Term Care

The benefit does not provide coverage for the "hard-core" drug and alcohol dependent individuals who need longer term care. The Administration's drug strategy vows to expand treatment to these individuals whose untreated problems impose the greatest costs. But the benefit, which would require only limited residential and outpatient substance abuse counseling, is an acute care model that does not address their needs.

Many individuals, including criminal offenders, pregnant addicted women, women with children, the homeless, adolescents, the elderly and people with chronic drug and alcohol problems, need longer term residential habilitation services ranging from six months to eighteen months, as is currently provided with federal, state and local funds. The Administration's proposed benefit may be appropriate for most individuals who are employed, have a fairly stable family or support system and whose substance abuse problem was diagnosed at an early stage and, thus, only need rehabilitation.¹¹ But it is not adequate for individuals with the most serious and chronic problems.

In addition, the Administration's benefit would make two levels of care that hold out the greatest promise for chronically ill individuals -- intensive nonresidential treatment and

¹¹ We also have concerns about how these individuals will fare under the Administration's benefit because of several unique features. First, the benefit would reduce the number of residential days available to an individual after he or she has received more than 30 outpatient substance abuse counseling visits on the basis of one residential day for every four outpatient visits. Second, utilization of the benefit will be strictly regulated by a "health professional designated by the plan," which under current practices has led to the denial of essential services and forced individuals to fail in an outpatient setting before being given residential care.

Putting these two features together, an individual could be required to attend outpatient services by the plan, reducing down the number of residential days available, and then have little residential care available upon failing in outpatient.

case management -- totally discretionary.¹² This feature does not meet the Administration's principle of providing a uniform benefit package across all plans. It will also enable health plans to continue risk selection because plans could avoid individuals who are high risk for a wide range of diseases, including HIV/AIDS, tuberculosis, cardiopulmonary illness, by simply not offering these levels of care.

Finally, eliminating these levels of care will undermine the ability of the health care system to provide a continuum of necessary services that individuals with chronic problems need. In the short run, the lack of these services will promote continued dumping of sicker individuals into the publicly funded system, if public funding to treat them still exists. In the longer run, it will be more difficult to integrate the publicly funded treatment system into the health alliances.

While the Administration has stated that the publicly funded system will remain in place to provide care that is not covered under the benefit package, we have grave concerns about whether sufficient federal, state and local funds will in fact be available.

First, the Administration has estimated that 65% of the treatment dollars available through the Substance Abuse Block Grant and federal categorical grant programs will be offset by the Act's substance abuse benefit. This figure, which was based on the Administration's September 7th proposal that was more comprehensive, is in our view totally off the mark whether based on the earlier or the current proposal. When several of the National Coalition member associations assessed the portion of services that would be offset by the comprehensive benefit, they estimated that no more than 30% would be covered. That figure is certainly reduced under the current proposal.

Second, State and local funding now accounts for approximately 45% of drug and alcohol treatment services nationwide, and states are currently required to maintain their level of funding as a condition of receiving federal block grant funds. State and local governments and charitable organizations invest substantial funds in longer term care. Under the Administration's plan, states and localities would not be required to maintain their efforts. Given the state financial responsibility under the Administration's proposal, there is a great likelihood that funds currently spent on drug and alcohol treatment will be diverted to fund other health care and that essential drug and alcohol treatment services will not be funded.

Thus, existing services could be severely reduced for individuals with the most serious drug and alcohol problems as well as those who are "dumped" from the health alliances due to limited coverage or restrictive benefit management.

¹² These benefits were not optional in the September 7th version of the plan.

2. Limited Coverage Because of the Merged Substance Abuse and Mental Health Benefit.

The drug and alcohol benefit would be merged with the mental health benefit under the Administration's plan. This means that individuals who need both substance abuse and mental health services will have access to only one set of benefits.

As a result, individuals with both mental health and substance abuse problems and individuals with HIV disease who may need mental health counseling as well as drug and alcohol treatment could easily exhaust the benefit and be without care.¹³ Considering the various swapping provisions in the benefit¹⁴, individuals with both needs could whittle down the residential benefit very quickly and, as a general matter, have no way of really knowing what their benefits are or planning their total care. This clearly does not simplify the delivery of health services for either consumers or providers.

Apart from these very real practical problems, the merger of these services reveals a lack of understanding about the diseases. Addiction and mental illness are two distinct diseases that are treated by different professionals in different settings and require different therapeutic approaches. The substance abuse treatment system developed because the mental health system and the general health care system were not providing appropriate care to individuals with underlying drug and alcohol problems.

There is no other set of illnesses for which the care is merged as well as limited in this fashion. It is analogous to saying that a woman with heart disease and breast cancer who has been hospitalized for the heart condition cannot get hospital care in the same year for breast cancer because she has exhausted her inpatient benefit. Or that a man with prostate cancer cannot receive inpatient treatment in the same year for injuries resulting from a car accident.

Moreover, the cost of these substance abuse and mental health services is dramatically different. Substance abuse treatment is much less expensive. The scope of substance abuse treatment seems to have been artificially and inappropriately capped, at least in part because of the cost of mental health services. This is borne out by a simple comparison of costs.

¹³ It is possible that there will be no publicly funded "safety-net" for individuals who need additional care, because the funds currently available under the Substance Abuse and Mental Health block grants and categorical grant programs will be eliminated to the extent a service is included in the standard benefit.

¹⁴ In addition to the swapping that would exist for outpatient substance abuse counseling and intensive nonresidential care (to the extent it is provided), individuals would also be permitted at the discretion of the plan to obtain more than 30 psychotherapy visits by reducing 1 day of residential for every 4 psychotherapy visits.

According to newspaper reports, the Administration is seeking a mental health/substance abuse benefit that would cost an average of \$240 to \$340 per person.¹⁵ One must assume that the proposed limited benefit fits that cost. Yet an analysis of the national expenditure for drug and alcohol treatment conducted by Lewin-VHI, Inc. estimates that current expenditures for substance abuse treatment in the public and private systems will amount to \$6.7 billion in 1993 or about \$25.75 per covered life. The current expenditure in the privately funded substance abuse system, which parallels the Administration's proposal more closely, is only \$13.55 per covered life.¹⁶ Clearly, the lion's share of the cost in the Administration's plan would be for mental health care.

As noted above, the cost of a comprehensive substance abuse benefit would be approximately \$45.10 per covered life. Thus, it is clear that far more comprehensive substance abuse services could be provided if the two services were separated and costed out independently.

3. Cost Sharing Requirements Will Be A Prohibitive Barrier to Many Individuals

The Administration's plan would require cost sharing for outpatient substance abuse counseling under all three arrangements (lower, higher and combination) and would impose specific deductibles and co-insurance for residential care and co-insurance for intensive nonresidential care (to the extent it is provided) under the higher cost sharing plan.

While the plan would provide some cost sharing reductions for low income families, under no circumstance would the co-payment requirement be reduced below the low cost sharing plan, unless a family qualified for AFDC or SSI. Thus, many poor individuals would have to pay \$10 for every outpatient substance abuse counseling session and \$25 for every family counseling session. Moreover, no outpatient counseling expenses or expenses for the second 60 days of intensive nonresidential care (to the extent it is provided) is counted toward the out-of-pocket limit. These are the only services in the Administration's plan for which the expenses are not counted toward the out-of-pocket limit.

These cost sharing requirements will be prohibitive for the vast majority of individuals who need to attend counseling sessions several times every week (and the many who could not afford even one visit) and, thus, will be a major barrier to obtaining necessary care and preventing relapse. The problem is only exacerbated by the fact that the co-payment requirement continues even if individuals and families incur catastrophic expenses.

¹⁵ The Wall Street Journal, November 5, 1993, B14. We are relying on newspaper coverage because the Administration has not yet disclosed the cost of the benefit.

¹⁶ H.J. Harwood, et al., "Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches." (Discussion Draft)

The cost sharing requirements have been imposed generally as a way to control utilization. But the value of such controls has no applicability in the case of drug and alcohol treatment because the care is underutilized to begin with. Individuals with drug and alcohol problems often deny having a problem and look for reasons not to obtain care. Many have lost their jobs and personal resources before finally recognizing the need to enter treatment. For these reasons, co-payments will be a disincentive for most people with drug and alcohol problems and a huge barrier to their ability to receive the services they need.

4. Unregulated Utilization Review May Result in Inappropriate Care.

The Administration's plan would strictly manage the utilization of substance abuse services by placing critical decisions in the hands of a "health professional designated by the plan." This individual would determine whether an individual in residential care could get more than 30 days of care at one time, whether an individual could get more than 60 days of intensive nonresidential services (if this discretionary services is provided at all) and whether an individual whose first detoxification was unsuccessful could receive another chance at detoxification. The Administration's plan would not impose any standards on the health professional's qualifications, experience or knowledge of substance abuse issues and would not impose any standards for his or her utilization review protocols.

While it is clear that the Administration's plan will rely on utilization review to control costs and utilization of all services, the removal and transfer of important care decisions from the drug and alcohol treatment provider to the plan is different from the standards that would apply in other types of care. For example, with home health care, after each 60 days of services, the need for continued care is reevaluated by the person "primarily responsible for providing home health care," not a different person designated by the plan.¹⁷ Similarly, the person primarily responsible for providing outpatient rehabilitation services -- occupational therapy, physical therapy and speech pathology -- is also given the authority to decide whether services continue after each 60-day period.¹⁸

There is no reason to believe that one set of providers would make less appropriate care or more costly decisions than another set of providers, yet the Administration's plan assumes this to be the case. Indeed, practice has taught that unregulated utilization review decisions by individuals who fit the description of a "health professional" often leads to the denial of necessary drug and alcohol treatment services and inappropriately restricted lengths of stay. If not properly performed, monitored and regulated by uniform standards, utilization review will lead to much greater costs. I have attached a set of principles developed by the Legal Action Center for the regulation of utilization review. (Attachment C)

¹⁷ Section 1118.

¹⁸ Section 1123.

C. Recommendations

To resolve the above concerns we recommend the following revisions.

1. Separate the substance abuse benefit from the mental health benefit and provide a comprehensive drug and alcohol benefit that addresses the needs of all individuals based on an individualized assessment of their problem.
2. To the extent a comprehensive substance abuse benefit is not included in the plan, retain the current funding level for the Substance Abuse Block Grant and other federal categorical grant programs and require States to maintain their investment in drug and alcohol treatment.
3. The outpatient substance abuse counseling benefit should be treated like a preventive clinic benefit with no cost-sharing requirements. In addition, the cost sharing for outpatient and intensive nonresidential services should be applied to the out-of-pocket limit.
4. Uniform utilization review criteria should be promulgated and the application of these criteria by plans should be closely monitored. In addition, the same utilization review and managed care standards contained in the legislation for all health services should be applied to substance abuse services.

Thank you for considering our views. We look forward to working with you as Congress crafts its health care reform legislation.

Substance Abuse Benefit: Health Security Act

<u>Mandatory Services</u>	Limitations ^a	Lower Cost Sharing	Higher Cost Sharing
Screening and Assessment	None	No Copayment	No Coinsurance
Crisis Intervention	None	No Copayment	No Coinsurance
Detoxification	1 Episode ^b	No Copayment	No Coinsurance
Residential/Inpatient ^c	30 days/episode 60 day/year would be reduced if other services used ^d	No Copayment	1 day deductible 20% of applicable payment rate
Outpatient Substance Abuse Counseling and Relapse Prevention	30 group therapy visits if initially treated in residential or intensive nonresidential Additional visits if not initially treated in other care level ^e	\$10/visit ^f	20% of applicable payment rate ^f
Medical Management ^g (Brief office visits to monitor medications)	None	\$10/visit ^f	20% of applicable payment rate ^f
Collateral Services ^h (Family Services)	30 visits	\$25/visit until Jan. 1, 2001 and \$10/visit thereafter ^f	50% of applicable payment rate until Jan. 1, 2001 and 20% thereafter ^f
Outpatient Prescription Drugs	None	\$5/prescription	\$250 deductible 20% of applicable payment rate

<u>Optional Services</u>	Limitations	Lower Cost Sharing	Higher Cost Sharing
Intensive Nonresidential	120 days/yr. ⁱ	No Copayment	20% of applicable payment rate
Case Management	Only provided individuals in outpatient care	No Copayment	No Coinsurance

Attachment A

- a. Day limits would be removed as of January 1, 2001.
- b. The only inpatient treatment allowed would be for medical detoxification from drugs or alcohol.
- c. The number of residential days would be reduced to the extent an individual was treated in an intensive nonresidential program (the first 60 days) or received more than 30 outpatient substance abuse counseling visits. Residential day would be reduced by 1 day for every 2 days of intensive nonresidential care and 1 day for every 4 outpatient visits.
- d. Additional outpatient detoxification would be provided only if a health professional designated by the plan determine that there is a "substantial chance of success."
- e. The plan is unclear as to whether these additional visits are only group therapy or also include individual therapy. These additional visits would reduce the availability of residential care by 1 day for every 4 visits.
- f. The copayment or coinsurance would not be counted to the out-of-pocket limit.
- g. This service would be applicable in a limited manner for individuals participating in methadone maintenance treatment programs. Individuals in such programs receive a range of counseling and health services in addition to the medication and monitoring services, which would not be covered by this level of care.
- h. Collateral services would be provided to family members if the drug or alcohol dependent individual is receiving treatment.
- i. The 120 day period would be divided into two 60 day periods. The first 60 days would be considered a substitute for residential care, and would reduce residential care by 1 day for every 2 days of intensive nonresidential. A second 60 day period would be provided if a health professional designated by the plan determines that additional treatment "medically necessary or appropriate."

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MODEL LEGISLATION MANDATING NATIONAL HEALTH INSURANCE BENEFIT FOR PREVENTION AND TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION

I. SPECIFICATIONS OF PREVENTION AND TREATMENT FOR ALCOHOL AND DRUG ABUSE AND DEPENDENCE

Coverage for the prevention and treatment of alcohol and drug abuse and dependence shall be comprehensive and allow for services in the setting most appropriate for each individual. Individualized assessments should be based on clinical necessity and govern the intensity and duration of treatment.

The system of care must take into account that individuals entering treatment have diverse needs, some requiring prevention, some rehabilitation and others requiring more intensive habilitation efforts. While most individuals will not require all the services outlined in the model, the model should be flexible enough to accommodate individuals with diverse needs. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, will be provided for children.

At the minimum, benefits should allow for the following services, with appropriate applications of individualized services through case management:

1. prevention - clinical screening, health promotion and education on risks of drug and alcohol use;
2. intervention - including assessment, diagnosis, and referral;
3. detoxification - 10 days of treatment in a hospital, non-hospital, or ambulatory detoxification program as medically necessary in any calendar year, unless medical complications require additional days;
4. outpatient treatment - a full continuum of outpatient services should be provided including:

a. intensive day and evening treatment: 40 days in any calendar year;

b. outpatient - 60 visits in any calendar year;

- c. continuing care - 60 visits in any calendar year;
- d. family outpatient care, including preventive services for children irrespective of treatment status of parent: 60 visits in any calendar year;
- 5. residential treatment -
 - a. short-term: 30 days of treatment in a hospital or free-standing program in any calendar year;
 - b. long-term: up to 18 months of treatment in a residential program (halfway and quarterway houses, therapeutic communities);
- 6. case management - unlimited and determined as clinically appropriate; and
- 7. pharmacotherapeutic intervention - unlimited and determined as clinically appropriate.

II. Alcoholism and Drug Dependencies Prevention and Treatment Benefit Definitions *

- 1. Prevention - patient education about the risks associated with alcohol and drug use.
- 2. Intervention (including assessment, diagnosis and referral) - a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral of the individual.
- 3. Detoxification - the medical and psychological management of an individual while he/she withdraws from alcohol and/or drugs.
- 4. Outpatient services -
 - a. Intensive outpatient/day treatment - an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of treatment consisting of regularly scheduled sessions of a minimum of nine (9) treatment hours per week within a structured program. Services are tailored to meet

* Some of these definitions were taken directly from the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, American Society of Addiction Medicine, March 1991.

the individual's needs, and include detoxification, medical management and psychological support.

b. Outpatient services - an organized non-residential service or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, treatment and recovery services to addicted patients. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

c. Continuing care - a structured therapeutic involvement designed to enhance, facilitate, and promote the transition from primary care to ongoing recovery. The principle criterion for admission to continuing care is participation and satisfactory completion of a primary care treatment and intent to remain abstinent of alcohol and/or other nonmedical psychoactive substances.

d. Family outpatient services - an organized, non-residential services or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, prevention, treatment and recovery services to the families of addicted individuals. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

5. Residential treatment -

a. short-term -- an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care, and treatment for addicted patients in a residential setting. Clinical services includes: medical; educational; and individual, group and family therapy.

b. long-term --

Halfway house care - an organized, long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual including educational and vocational rehabilitation and locating permanent housing.

Three-quarter-way house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides ongoing support and supervision for individuals who are resuming activity in the community.

Therapeutic community - an organized long-term residential service (up to 18 months) with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual, including educational and vocational rehabilitation and locating permanent housing.

6. Case management - supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.
7. Pharmacotherapeutic intervention - an organized medical intervention with a patient under the supervision of a licensed physician that utilizes approved medications such as methadone or Antabuse in conjunction with comprehensive medical, casework and counseling services.

Principles for Regulating Utilization Review

1. A process for certifying or licensing the bodies conducting utilization review;
2. Provisions requiring the disclosure of the specific admission and treatment criteria used in determining the justification for any form of hospital, residential or outpatient services;
3. A description of an emergency preauthorization procedure that will include the process for allowing a smooth admission process for assessment and detoxification;
4. A description of the procedures the review agent will follow when making decision, including:
 1. policies and procedures to ensure that all applicable state and federal laws that protect the confidentiality of records are followed;
 2. a time frame within which decisions on admissions are made (we recommend that a decision be made within 24 hours of a request, and that a second opinion be obtained within 24 hours in the case of any adverse determination);
 3. procedures by which the review agent shall notify the insured and providers when payment for alcohol or drug treatment is denied or limited, including a written statement for the denial or limitation;
 4. a provision that if a course of treatment has been preauthorized or approved for a patient, a private review agent shall not subsequently, including during any retrospective review, revise or modify the specific criteria or standards used for the utilization review for services delivered to that patient.
5. A description of an independent appeals process;
6. A provision requiring the disclosure of the names, addresses, telephone numbers, and qualifications of the personnel who will be performing utilization review for alcohol and drug treatment services, who shall be at least:
 1. a licensed practical nurse or licensed registered nurse with experience in the treatment field or health care professional with experience in the treatment field, for performing initial review;
 2. a licensed physician actively practicing or who has demonstrated expertise in the treatment field in initial denial determination prior to a final denial determination by the insurer.

7. Procedures to ensure that review agents will be readily accessible by telephone to the insured and providers at least 40 hours per week during normal business hours, and assurances that a toll-free telephone line will be provided for insureds, hospitals, and physicians to contact the review agent;
8. Procedures to ensure that the review agent will respond by telephone to insureds and/or providers within four business hours;
9. Procedures to ensure that no review agent shall enter a hospital or other treatment facility of a provider to interview an insured unless such activity has been approved in advance by such insured's attending physician or treatment counselor and such attending physician, counselor or designee shall be able to attend such activity which shall occur only during regular business hours.
10. A provision that no private review agent who will be performing utilization review shall enter into a contract or arrangement of any kind which provides that any compensation or benefit to be received by any such person is directly or indirectly, in whole or in part, affected by a determination of whether or not the insured's admission to or continued treatment is or is not medically necessary or appropriate.
11. A provision that a list be provided of third party payors for which the private review agent is performing utilization review;
12. Penalties for failure to comply with the law.

**National Coalition of State Alcohol and Drug Treatment
and Prevention Associations**

Alabama Alcohol and Drug Abuse Association
 Arizona Association of Behavioral Health Programs
 California Association of Alcoholic Recovery Homes
 California Therapeutic Communities, Inc.
 County Alcohol and Drug Program Administrators
 Association of California
 Florida Alcohol and Drug Abuse Association
 Georgia Association for the Prevention and Treatment
 of Substance Abuse
 Illinois Alcoholism and Drug Dependence Association
 Iowa Substance Abuse Program Directors' Association
 Maine Association of Substance Abuse Programs
 Massachusetts Alcoholism and Drug Abuse Association
 Nevada Association of State Drug Abuse Programs
 New Jersey Association for the Prevention and Treatment of Substance Abuse
 New York State Association of Substance Abuse Programs
 North Carolina Association of Alcohol and Drug Service Administrators
 Association of Ohio Substance Abuse Programs
 Drug and Alcohol Service Providers Organization of Pennsylvania
 Drug and Alcohol Treatment Association of Rhode Island
 Tennessee Alcohol & Drug Association
 Wisconsin Association on Alcohol & Other Drug Abuse



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Mr. LEWIS. Thank you, Ms. Weber.

And let me thank each member of this panel for your moving statements. Everything that you said will be part of the record. The written statements have also been submitted for the record.

Thank you very much.

The hearing will now stand adjourned

[Whereupon, at 2:05 p.m., the hearing was adjourned.]



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